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ABSTRACT

This interim report of the Temporary New York State Commission to Evaluate the Drug Laws seeks to provide the executive department and the legislature with comprehensive information on the social, fiscal and health problems associated with narcotics addition, and drug abuse. This report is the result of the following: (1) several meetings with treatment, research and law enforcement personnel; (2) a series of visits to treatment and research facilities throughout the state; (3) a variety of questionnaires answered by representatives from more than 400 programs in the state; and (4) six public hearings. The report is sharply critical in many areas; however, no other state has even begun to approach the comprehensiveness of the treatment programs available in New York. Topics discussed in the report include: (1) the methadone controversy; (2) abstinence programs; (3) alcoholism--emphasis without stress; (4) children and parents--time for reconciliation; (5) the Drug Abuse Control Commission; and (6) drunk driving. (Author/PC)

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Anomalies in Drug Abuse Treatment

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Interim Report of the Temporary State Commission To Evaluate the Drug Laws

Assemblyman Emeel S. Betros, Chairman

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LETTER OF TRANSMITTAL

To The Governor and The Legislature of The State of New York:

Pursuant to Chapter 474 of the Laws of 1970, as amended in 1974, the Temporary State Commission to Evaluate the Drug Laws hereby respectfully submits the following report.

Assemblyman Emeel S. Betros, Chairman

Judge Irving Lang, Vice Chairman

Senator Robert Garcia, Secretary

Henry Brill, M.D.

Senator John R. Dunne

Senator Joseph L. Galiber

Assemblyman Alan G. Hevesi

Senator Tarky Lombardi, Jr.

Assemblyman Dale M. Volker

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ACKNOWLEDGEMENT

On behalf of the Commission I wish to express our appreciation to the many witnesses who took the time to testify at our hearings, and to the treatment, research, and law enforcement personnel who cooperated with Commission staff members in helping to analyze the present dimensions of the drug problem, as well as current treatment techniques.

EMEEL S. BETROS
Chairman

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INTRODUCTION; FINDINGS AND RECOMMENDATIONS

The Temporary State Commission to Evaluate the Drug Laws has, in its five year history, addressed the problem of treatment on three prior occasions. In 1972, the Commission advocated a comprehensive system of regulating the manufacture, distribution, and therapeutic application of controlled substances, which would protect against the diversion of mood-altering drugs, but which could also encourage the expansion of treatment and research (Controlled Substances, Legislative Document No. 10, 1972). The Commission then carefully balanced the risks and the opportunities entailed in the employment of genuinely rehabilitated addicts, and found that a verifiably good rehabilitation or work record coupled with the capability to perform a specific task were sufficient to reduce the risk of employing reformed addicts to essentially that of employing persons with no history of addiction (Employing the Rehabilitated Addict, Legislative Document No. 10, 1973). Also, in 1973, the Commission carefully evaluated reasons for the success of other countries in dealing with their own drug problems and found that the underlying principle of successful rehabilitation always included attempts, with proper safeguards, to reintegrate the addict with society (How People Overseas Deal with Drugs, Legislative Document No. 11, 1973).

One of the most striking observations made by the Commission, while abroad, was that whatever success the Japanese, the British, the Dutch, or others could cite with regard to

preventing drug abuse, the most significant common denominator was often positive action to promote the individual health and development of each child. This observation became the thesis of our study of American drug abuse prevention techniques, particularly those being attempted in New York State (Drug Abuse Prevention, Legislative Document No. 11, 1974). While analyzing the question of prevention, we discussed the role of treatment as a tertiary form of prevention, that is, after the fact of drug abuse. It became clear to us that the treatment of drug and alcohol abuse in New York State was so complicated by philosophical and practical questions that further analysis would be justified, under our mandate "to provide the executive department and the legislature with comprehensive information on the social, fiscal and health problems associated with narcotics addiction, and drug abuse..."*

This report is the result of a series of visits, both announced and unannounced, to treatment and research facilities throughout the State. It is the result of several meetings with treatment, research and law enforcement personnel. It is the result of tireless efforts by the Commission staff to read through hundreds of books, papers and monographs on the subjects discussed in this report. It is the result of a variety of questionnaires answered by more than four hundred programs throughout the State. It is also the result of six public hearings held: in New York City on September 4, 1974;

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*Chapter 474, Laws of 1970.

in Mineola, Long Island on September 5th; in Buffalo on September 24th; in Syracuse on September 25th; and in Poughkeepsie on October 2nd. A joint hearing on drunk driving was held by this Commission with the Joint Select Committee on Transportation and the Senate Standing Committee on Transportation in Mineola, New York, on October 17, 1974.

Although this report is sharply critical of many aspects of drug and alcohol abuse treatment in New York State, we believe that two prefatory qualifications are vital to an understanding of the treatment problem in its true perspective. First, no other State has even begun to approach the comprehensiveness and true diversity of the treatment programs in New York.* Except in the area of alcohol abuse, the faults we find are those of unsuccessful planning; they are not mistakes resulting from not caring. Second, while we tend to support the methadone maintenance approach, among other modalities of treatment for heroin addiction, we are also mindful of the drawbacks of methadone, and we fully encourage efforts to develop long-acting narcotic antagonist compounds which could both ease the termination of narcotic drug abuse and, at the same time, discourage further drug-seeking behavior among addicts.

RECOMMENDATIONS

Methadone

1. In light of the controversy over methadone death statistics in New York City, the Commission recommends an expansion of the authority of the State Health Department to

*Indeed, as this report goes to press, indications from other states, including California, point to a possible recrudescence of the heroin problem. This is a development that must be watched carefully, with respect to the needs of New York State.

investigate and monitor the operation of the New York City Medical Examiner's Office, particularly with regard to its development of statistical data. Such authority should also extend to other Medical Examiners' Offices throughout the State.

2. There is a need to promote employment among rehabilitating addicts in methadone maintenance programs. The Commission endorses the requirement of the Drug Abuse Control Commission that one vocational counselor be retained for each one hundred fifty patients. We invite the attention of providers of treatment to the excellent work being carried on in this field by the counselors and job placement workers at the Nassau County Drug and Alcohol Addiction Commission. We believe serious consideration should also be given to the study of such programs as that at Long Beach Memorial Hospital, with a view toward utilizing openings in hospitals, themselves, as structured vocational training slots.

3. We find that the use of public funds to provide free methadone treatment to working patients who can afford to repay some of the cost of that treatment is counterproductive.

(a) We call upon the Comptroller of the State to audit state outlays of funds, including Medicaid reimbursements, for patients capable of assuming a portion of the cost of their own care.

(b) Without engaging in aggressive collection procedures, non-profit drug treatment programs should permit their working patients to contribute a flat-rate weekly fee, such as three dollars per fifty dollars of take-home pay. In this way, the State could reduce the annual cost of methadone maintenance by upwards of five million dollars.*

*An estimated sixteen thousand patients are now able to pay upwards of six dollars per week on this basis.

4. Methadone programs should provide greater recreational outlets for patients, to discourage indecorous confrontations with neighbors of such programs. Community leaders should work along with methadone programs to overcome problems of objectionable conduct by patients. Each facility should maintain an observation of its clients in the neighborhood.

5. To enhance the employability of rehabilitating addicts, the present federal requirement that persons in treatment for longer than two years must report to a clinic at least twice a week should be changed to at least once a week after one year.

6. The Drug Abuse Commission should consider a more specific regulation that methadone clinics open early in the morning or during the evening to permit working patients to pick up their medication without calling attention on the job to their need to do so.

7. Complaints about the rigidity of the current mechanism for granting exceptions to D.A.C.C. methadone regulations have led us to recommend the establishment of an advisory committee, comprised of providers of treatment, as well as D.A.C.C. officials, to advise as to measures to expedite decisions in this regard.

8. The State Health Department should suspend all Medicaid payments to methadone clinics, beginning with profit-making clinics, which are unable to provide actual, meaningful back-up medical and psychiatric care.

9. The Drug Abuse Control Commission should inquire of treatment programs throughout the state as to the feasibility of providing formal psychiatric, psychological and social work evaluations and treatment of clients requesting such services, either through meaningful liaisons with community providers of

such services, or through the incorporation of such services into treatment programs, themselves.

Abstinence Programs

While D.A.C.C. has assumed that the standards we recommend are or should be operational, we believe that the following specific written regulations relating to D.A.C.C. funded facilities would be more productive than the general workscopes now utilized:

1. Smaller programs should be required to concretize their services in as explicit a fashion as possible, and, consequently, their admissions criteria, as well.

2. Larger programs, particularly those which admit persons not abusing drugs or persons only minimally involved with drugs, should be required to offer a full range of services, as described herein.

3. All programs should be required to demonstrate the immediate accessibility of medical and psychiatric evaluation back-up services.

4. Periodic urinalysis and reporting of results of urinalysis to D.A.C.C. should be required of all patients who maintain significant contacts with drug-free programs. Since certain tranquilizers and alcohol may not be detectable in urine samples, programs should be required to demonstrate their capacity to identify individuals abusing such substances.

5. Professional and paraprofessional staff integration should be explicitly detailed, and heightened emphasis placed upon professional capacity to facilitate patient reentry into the general population.

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Beyond these recommendations for additions to D.A.C.C. regulations, we further recommend the inclusion of outreach and recreational components, such as dayrooms, in all drug programs.

Alcohol

A. Research:

1. At the present time the State spends approximately six million dollars each year directly on various modalities of treatment for persons who have alcohol-related problems. The State also appropriates over one hundred million dollars per year for drug treatment programs, for an actual and a potential client population perhaps one third as large as the State's problem drinking population. As the focus shifts to providing more services to persons with alcohol and polydrug-alcohol problems, it would be sound social policy to begin a study of each of the present treatment modalities, with an evaluation of success with patients within each type of program, as well as a comparison of the success of different types of programs. In that way, repetitions of the mistakes made in the hurried establishment and funding of drug programs may be avoided.

2. Continued pressure should be brought to bear upon funding sources to combine research with treatment, for the purpose of establishing pilot treatment programs on a purely research basis, so that results may be evaluated concurrently with the delivery of treatment services. Viewed in this perspective, new forms of treatment would become aspects of research.

3. Epidemiological studies are useful in determining the scope of the problem. Cooperation between the State Health Department and the Alcohol Research Institute might serve to stretch precious resources while accomplishing this purpose.

4. When speaking of the subjects of alcohol and education, many people refer to the idea that educational efforts regarding "values clarification," "decisionmaking," and warnings against alcohol abuse may deter each abuse. Efforts in the past that have failed often prompt the search for a new jargon and catchier slogans, and declarations that future efforts will avoid previous mistakes. A full analysis of these ideas appears in our report on Drug Abuse Prevention (cited above). Aside from informing people about the nature of human dysfunctions and calling their attention on an individual basis to their own problems in this regard coupled with giving them opportunities to receive help, there is little that education can achieve in the sense of deterring substance abuse solely through verbal manipulative techniques.

However, education in the sense of teaching professionals how to deal with problems of alcohol abuse among their patients and their clients has been a much neglected area of concern. According to the Department of Mental Hygiene, there are seven subdivisions of students whose ultimate clients and patients would benefit from educational efforts at this level. These subdivisions of students are those involved in professional degree education, such as medicine, psychology, nursing, social work and law; those involved in post professional degree education; undergraduates seeking degrees in health care or human services; candidates for in-service education within existing agencies; participants in continuing education for professionals; those likely to attend periodic workshops; and alcoholism counselors.

We recommend that the Alcoholism Research Institute prepare courses of study for these categories of students, particularly family physicians, whose lack of familiarity with alcohol-related problems has been well documented.*

5. The excellent work of Alcoholics Anonymous is well known. For some of the persons who cannot respond to traditional psychiatric intervention and casework, A.A. represents not only a last hope, but a real hope. According to A.A. nearly half of the people who remain members never drink again. Virtually every worthwhile treatment program today offers easy access to A.A. We believe that a prime research effort should be made to understand conceptually how A.A. achieves its results, and to what extent the concept might be broadened, without inviting the errors of the therapeutic communities.

Other studies of the Institute should, of course, proceed. And in order to meet the suggested order of priorities, additional funding may be needed. Our recommendation in this regard is that moneys saved in the drug abuse field should be reallocated to alcohol research. Beyond those savings, however, additional funds may ultimately be needed for further alcohol-related research and treatment. In recommending that such increases be preceded by meaningful evaluations, we are also mindful of the fact that revenues from the sale of alcoholic beverages in New York State exceed three hundred fifty million dollars, annually. The damage to the State of alcohol-related problems

*Planning Guidelines, New York State Department of Mental Hygiene, 1973-1974, pp. 69-73.

is estimated to be over one billion dollars. Yet the State spends only seven million dollars for treatment and research. We do not urge spending for its own sake. However, we also do not oppose justifiable increases in expenditures for evaluations and for programs that work.

B. Treatment:

Alcohol-related problems occur with varying degrees of severity and at differing points in time among a variety of individuals. It is necessary that treatment services be provided in a comprehensive and systematic way, with built-in mechanisms to assure accessibility to the services, continuity of care, and availability of treatment for as long as individuals require it. Programs should not be developed which are piecemeal in character, possibly leading to "revolving door" utilization without significant impact on the individuals involved.

Children and Parents

This Commission finds that in the absence of a real effort to shore up families, funds spent on treatment of child drug abusers are often wasted.

Therefore, this Commission recommends:

1. Funding for research and pilot programs exploring the use of family counseling, including family therapy. Guidelines should encourage the inclusion of family counseling services in drug programs, or in a nearby community facility working cooperatively with the drug program.

2. A training program in family counseling and family therapy skills for both professionals and paraprofessionals in the drug abuse field.

3. The encouragement of family therapy and family counseling in present neighborhood based facilities, public and private, such as community mental health centers, other Health Maintenance Organizations, community centers, churches. Such services can be publicized through P.T.A.'s neighborhood associations, and narcotic guidance councils.

4. Families should be kept together. We recommend:

a. That placement should be viewed as a last resort. Placement should be viewed as a temporary condition, with the expectation acknowledged that eventually the child will return to his family and the family should be prepared to cope with him constructively.

b. The provision of concrete services to strengthen the families of children in trouble, those using drugs and those expressing their troubles in other ways.

c. Imaginative and creative planning by social service professionals, to use the assets available to a child, such as relatives and neighbors who care about him.

d. Neighborhood based service centers of various kinds do exist. Their work should be coordinated, so that cooperatively in the aggregate they offer a comprehensive range of services.

e. Coordinating programs which service the senior citizens with those which service families. A major problem with senior citizens is their sense of valuelessness and loss of self esteem when they retire or when their children are all grown. Children and young parents in the inner city suffer from the absence of grandparents, aunts and uncles. If the two groups can come together, both gain.

5. When Placement is necessary:

a. There should be flexibility in the use of resources, including placement resources, so that each child's plan is tailored to his needs, not the agency's.

b. When placement of more than one child in a family is necessary, the siblings should be placed together.

6. Acceptance of responsibility for a child by one agency, and when possible one social worker, on a continuing long term basis, no matter where that child is living, until he or she has been lauched on a life-program which is satisfying to him and to society. The model for this assumption of continuing responsibility exists in jurisprudence. A Judge can assume continuing responsibility for a case, and that case will then return to that Judge for review and supervision at any time in the future. It is high time that the social work profession recognized how essential it is to the well-being of a child that there be one helping adult to whom he can turn whatever vicissitudes of life assail him. There is nothing in law or guidelines preventing the assumption of such responsibility for each child. In point of fact, in many cases, as in the one cited herein,

prime responsibility for the family does rest with one agency, the Department of Social Services, from the child's birth to maturity. That Department even in some cases has statutory responsibility to supervise the services offered that child by other agencies, because it must approve reimbursement to such agencies. What is missing is the personal responsibility of a single worker supervising, in substance, not form -- a worker who knows the child.

The Drug Abuse Control Commission

1. D.A.C.C. has been reexamining its role as a primary provider of treatment. We adopt as a recommendation the view implicit in the January, 1974 report of the Legislative Commission on Expenditure Review that while continuing to fund other treatment programs, D.A.C.C. should continue to reexamine the scope of its role as a primary provider of treatment.

2. We recommend the development of a Drug Research Institute to bring together the work of existing New York State drug research undertakings and to develop them into a comprehensive institute, similar to the Alcohol Research Institute, with which its work should be closely coordinated. We further recommend that the Drug Research Institute begin evaluations of all drug programs throughout the state, public and private.

3. We recommend that the State Comptroller perform an audit of the operations of D.A.C.C. and D.A.C.C. funded agencies and facilities.

4. Pending the creation of an agency to deal with all addictions, we recommend that the Department of Mental Hygiene Division of Alcoholism be given expanded authority to treat

polydrug abusers with alcohol problems.* We believe that D.A.C.C. and the Department of Mental Hygiene Division of Alcoholism should be required to promulgate regulations governing treatment in drug programs of polydrug abusers with alcohol-related problems. For doubtful cases, there should be a joint local referral committee to decide which agency will take responsibility.

Drunk Driving

Pending the completion of a report to the Legislature by the Department of Motor Vehicles on their estimate of the effectiveness of drunk driving programs in this State, this Commission's recommendations based upon the overview presented here, should be, and are, made in principle:

1. The mandatory diversion of drinking drivers to educational programs, such as the one in Dade County, Florida, would appear to serve two purposes:

a. The casual drinker who is convicted of drunk driving may learn the full nature and the consequences of his conduct and how to avoid such conduct in the future; and

b. The problem drinker or alcoholic may be able to come to understand that drunk driving represents only one of several dysfunctions related to the use of alcohol. Recognizing other dysfunctions may be the first step towards developing motivation for treatment.

In this latter context, no countermeasures program could possibly be effective without the incorporation of trained personnel in the helping professions, and also representatives

*Prompt medical evaluation and treatment are particularly essential in dealing with drug abusers who also use alcohol.

of Alcoholics Anonymous, both to help the individual recognize his problems, as well as to help him secure treatment.

2. Because we are also recommending evaluation of the effectiveness of current treatment approaches to alcoholism, we believe that it would be premature to impose mandatory treatment requirements for convicted drunk drivers, at this time. However, the voluntary participation of person in a treatment program for a period of time, and evidence of the alleviation of other alcohol-related problems, might be useful considerations in the determination to restore his license.

3. The reluctance of juries to convict persons charged with drunk driving offenses may be attributable to three causes:

a. Juries identify with defendants, because jurors themselves, tend to drive after drinking. If this is the case, nothing short of a total ban upon the operation of a motor vehicle soon after drinking, regardless of how little or how much, could possibly be effective as a penal sanction.

b. Jurors do not feel that drunk driving is serious. This seems unlikely.

c. Jurors may have intuited that drunk driving is a medical problem and that the penalty structure is irrelevant to its meaningful solution.

It seems to us that the most likely reading of the difficulty prosecutors report in achieving convictions for drunk driving is this third possibility, that juries believe the problem is not one of appropriate criminal sanctions, but rather, a problem

based upon the motivation for and the availability of treatment. Seen in this light, we recommend that further study be given to the following procedure to be used in New York State:

First, empower the police to administer a roadside or a station house chemical test. If the driver fails the test, allow the police to suspend his license, and give him the option of a criminal proceeding, under the penalty statutes, to clear himself, or a civil proceeding to regain his license.

Second, if the fact of drunk driving is established either way, mandate participation in a countermeasures program for purposes of establishing the eligibility of such an individual to regain his license.

Third, make specific offers of meaningful evaluation and treatment to apparently debilitated or troubled drinking drivers, with a view towards dealing with the underlying causes of their unwanted behavior, and thus, perhaps, reduce the overall problem by the successful outcome of treatment in a significant number of individual cases.

In the event that the Legislature should conclude that a reduction in penalties would lead to a greater number of convictions in drunk driving cases, we would also suggest, as a condition thereof, the enactment of mandatory participation in a countermeasures program, such as the one described in our previous report, Drug Abuse Prevention (cited above).

CHAPTER I

RESOLVING THE METHADONE CONTROVERSY

Methadone is a synthetic opiate, technically an opioid. The opiates have a long history as analgesics. The use of opium and, later, morphine to prevent medical complications and death as a result of intense pain is well known. Morphine was first introduced into widespread medical use during the American Civil War. The addictive properties of the opiates became a social problem during the Industrial Revolution, when narcotic addicts could be found among injured war veterans, women who had been given excessive doses of morphine during childbirth, and among certain alcoholics, for whom alcohol was apparently not enough. Around the turn of the century, a German pharmaceutical firm (Bayer) marketed what was at first thought to be a safe, non-addictive analgesic called heroin. Heroin is an opiate, a further refinement of morphine. It was sold over the counter as a cough remedy, and was also used as a analgesic, until its addictive properties became widely known. During the 1920's, it is said one of the reasons abuse of the stimulant cocaine became fashionable, was the disreputable status of opiate addiction, which even then, claimed as many as two hundred thousand victims. Despite the enactment and enforcement of strict laws against the unlawful possession and sale of narcotics and despite the total medical proscription of heroin, the addict population remained relatively stable until World War II.

Since all heroin is manufactured outside the United States, the War interrupted its illicit importation. Unfortunately, the basic social conditions which created a market for heroin did not improve, and to a great extent, alcoholism was seen increasingly in addition to heroin and cocaine use throughout poorer sections of the country. After the Second World War, illicit narcotics traffic resumed, again striking at poor people. The consumption of alcohol increased, as well. In addition, abuse of amphetamines and barbiturates were more frequently seen. Between 1921 and 1967 no treatment was generally available in New York State for heroin addiction, and very little was available for alcoholism. Both types of illness were on the rise, however, and inflation coupled with wider medical demands for the legitimate production of opium, which has always been susceptible to diversion for the manufacture of illicit morphine and heroin, began to give an even more sinister cast to the heroin problem in America: Few people could afford the increasing doses of heroin needed to maintain the desired euphoria, without engaging in crime to secure the necessary funds to pay for the drug.

The fact that Americans, in particular, seem to equate euphoria with happiness is a phenomenon probably associated with the combination of a sophisticated technology that promises manufactured happiness, in the sense of unremitting elation, and the frustration of postponing one's share in that manufactured happiness, or in the sense of loss of an elation that could never have been sustained, when the manufactured happiness is recognized

by the more affluent for the instant trash it usually turns out to be. A consumer society, with its eye on unremitting elation, was tempted to spend billions of dollars on health care, mental health, housing, education, crime and addiction, and did so, without once adverting to that time-honored maxim of receiving a dollar's worth of value for each dollar spent. Perhaps the widening availability of a variety of substances, including mood-altering drugs, allowed us to make the logical leap from the problem observed to the problem solved, without timely inquiry into the effectiveness of our programs, let alone their cost-effectiveness, and without proper caution with regard to the acceptance of mood-altering drugs, such as the minor tranquilers, as substitutes for personal problem solving. When the abuse of heroin and other drugs usually anathematized along with it became current among middle-class young people, and when addiction-related crime began to spread, there was a sharp demand for a treatment response by government. The irony in the United States was that general medical care became available first to drug addicts, a fact to be remembered when considering sources of hostility which later developed towards drug treatment programs.

During World War II, the Germans were cut off from their supplies of opium. In 1942, German scientists were able to synthesize a narcotic similar to morphine, without recourse to opium or its derivatives. The drug was methadone. More than twenty

years later, Drs. Vincent Dole and Marie Nyswander of Rockefeller University developed the idea that methadone was somehow different from other narcotics. It was well known that cross-tolerances could be demonstrated among narcotic drugs. However, the desire for increasing dosages, whether psychological or physiological, could not be deterred by the substitution of one narcotic for another. Dole and Nyswander postulated that methadone, with its different origin, might satisfy a craving for other narcotic drugs even when a level of tolerance was reached. The basic Dole-Nyswander approach was:

1. Detoxify the addict from heroin, using methadone.

2. Gradually increase the oral dosage of methadone to between 80 and 120 milligrams per day.

3. At a stable dosage of 100 milligrams of methadone a day:

(a) The heroin addict would not go through painful withdrawal;

(b) The addict would soon lose all sense of euphoria and side-effects from the methadone, enabling him to function normally;

(c) The addict would no longer crave narcotics, and additional self-administered narcotics would have no effect;

(d) The addict's health would no longer be threatened by adulterated drugs, dirty needles, collapsed veins and other problems associated with heroin use; and

(e) The addict would be available for counseling, therapy, and rehabilitation, to guide him away from criminal activities and

toward socially constructive endeavors. Rehabilitation would also serve as a deterrent to the substitution by the addict of non-narcotic drugs to waste away while achieving "a high".

The theory was extremely attractive, because of the continual failure of other forms of treatment. The most notable series of failures occured subsequent to the release of heroin addicts from the penitentiary. As a consequence of having been denied narcotics while in prison, addicts emerged apparently no longer physically addicted to heroin. However, the craving for the drug tended to overwhelm so many of them, of such varied backgrounds and of so many differing potentialities for rehabilitation, that the reality of this aspect of addiction had to be recognized. Theories of addiction began to proliferate. Some viewed addiction as a problem of weak character. Some thought addiction was a product of mental illness. Some surveyed inadequate social conditions and indicated they thought there was just so much people could take. Some spoke of subtle biochemical changes induced by drugs. All observers were fascinated by, if apprehensive about, the backfire concept of using an addictive drug to arrest the undesirable aspects of an ongoing problem of addiction.

The backfire concept in medicine is not new. It was rediscovered by Dr. Edward Jenner, who guessed that a mild inoculation of cowpox could prevent smallpox. The germ theory of disease, which explained this discovery, was developed by Pasteur, who was born the year before Jenner died. The most modern adaptation of the backfire concept of medicine is the use of methotrexate* in

*See Statement of Dr. Jerome Jaffe, then Director of S.A.O.D.A.P., November, 1971.

certain forms of cancer. A lethal dose of this highly dangerous drug is administered to a cancer victim. Thereafter, an antidote is administered. The cancer is somehow liquidated, and often the patient survives. There is no accepted explanation for this discovery at this time.

To the layman, the introduction of a disease to prevent a disease, or the induction of a lethal process to arrest a lethal process, may have the ring of charlatanism about it. On the other hand, an idea which would sound facetious in a drawing room, may open new vistas of knowledge when developed by careful and respected researchers. Progress in science is not the product of ideas which may occur at random to anyone, but of the occurrence of a particular idea significantly within a carefully planned research framework.

Nevertheless, when scientific discoveries are offered as instruments of social policy, great care must be taken to compare the social conditions sought to be remedied with the original experiments which led to the discoveries. The apprehensions surrounding an application of methadone maintenance as a common form of treatment for narcotic addiction could not be and were not dismissed lightly. At Rockefeller University, Dole and Nyswander found that the five attributes of methadone maintenance that had been postulated could be demonstrated. The Food and Drug Administration authorized the use of methadone to maintain addicts on an experimental basis in several selected cities, including New York City, New Haven, Philadelphia, Washington, D.C. and Chicago.

Opposition to this modality focused upon the following concerns:

1. If methadone has the same subjective significance to the addict that heroin has, then society is yielding to the immoral desires of the addict.

2. Methadone may have incapacitating effects, similar to those of heroin. Consequently, its use may eliminate crime, but not increase the capacity of the individual to function productively. It may also cause the individual, who could require methadone for the rest of his life, to become dependent, in a physical sense, on the government or on private sources bent upon exploitation.

3. To the extent that drug addiction is symptomatic of psychogenic or internalized socio-economic factors, methadone may block efforts to engage the patient in therapy or meaningful resocialization.

4. Methadone may be diverted for profit and create a danger of overdose and primary methadone addiction.

Between 1969 and 1971 over 50,000 heroin addicts were placed on methadone maintenance. The Special Action Office for Drug Abuse Prevention gathered together all of the statistical data then available from the Food and Drug Administration, law enforcement agencies, and scientists. The evidence was mounting that persons maintained on methadone were likely to decrease their criminal conduct at the same time they were becoming rehabilitated in terms of social and vocational adjustments. Late in 1971, the

Special Action Office announced its recommendation that methadone maintenance no longer be considered an experimental treatment modality.

Because of what was believed to be the epidemic nature of heroin addiction, and the inability of public facilites, such as Beth Israel Hospital in New York City, to satisfy the need reflected by enormous waiting lists of addicts seeking treatment, the federal government had licensed a number of private practitioners, during the 1960's, to maintain patients on methadone. For the most part, such practitioners were ethical and performed a needed function. But several were nothing more than wholesale drug dealers, and their indifference to considerations other than profit left an unpleasant taste for private clinics with the public and also set the stage for the promulgation of extremely restrictive regulations, first at the federal level and, later, at state and local levels. (Digests of regulations are appended to this report.)

The decision of the federal government to approve the use of methadone maintenance as a treatment modality was based upon satisfaction that objections to such treatment could be overcome. To those who argued that the use of methadone was a sign of yielding to immorality, the federal government responded with requirements for frequent urinalysis and a requirement that no person be admitted to a program unless a dependence on narcotic drugs for at least two years could be demonstrated. The theory was that within that two-year period, the addict should have exhausted other avenues of assistance. Moreover, addiction for

less than two years was considered as insufficient reason for transfering a patient onto methadone, from which detoxification takes somewhat longer than from heroin.

The objections that methadone might incapacitate an individual in terms of work or education, and might make him incapable of exercising his rights against treatment programs, were overcome by studies demonstrating the alertness, the excellent work records, the good coordination and the swift, appropriate reactions of persons maintained on high doses of methadone (Employing the Rehabilitated Addict, Commission Report, Legislative Document No. 10, 1973). Moreover, the regulations were drafted to ensure the availability of medical, counseling and vocational services to the addict. A later regulation called for an explanation of the reasons for maintaining a patient on methadone longer than two years.

Another concern of those who objected to methadone maintenance was that of diversion. The regulations required that take-home privileges be extremely limited, and that in no event should any person be permitted fewer than two visits to a clinic each week, regardless of his length of time in a program.

With regard to the issue of whether methadone masks psychogenic or internalized socio-economic drug abuse etiologies, the debate continues. However, those who supported the increased availability of methadone pointed out that while any social problem can be reduced to the workings of the human mind, addiction may be more of a sociological, rather than a psychological development.

Seen in this light, the proof of an addicts "cure" is not an abstract measure of his mental health, but his satisfactory behavior over a period of time.

PRIVATE VERSUS PUBLIC

There are one hundred eighty-one methadone clinics in New York State, serving upwards of forty thousand patients. Of these clinics, one hundred fifty-three are in New York City, twenty-two of which are private, profit-making ventures. Other New York City programs are operated by the City, itself, and by voluntary agencies, such as Beth Israel Hospital. The clinics in New York City serve a total of upwards of thirty-three thousand patients, over eight thousand of whom are in private programs.

Prior to the issuance of federal regulations removing methadone from its experimental status and approving it for general use under strict guidelines, serious concern had arisen regarding a few unscrupulous practitioners who sold methadone for profit. Although the worst offenders were closed down, in an effort to which this Commission contributed, some observers came to view the profit motive as inconsistent with the operation of a methadone clinic in the public interest and in the interests of its own patients. Continued diversion of methadone, subsequent to the promulgation of new federal regulations, was inferred by some to originate with private programs, and, therefore, supported this contention.

In attempting to analyze this question, the Commission staff has met with community leaders, government officials, and providers of treatment. The staff has also visited methadone treatment programs, both public and private, around the state, and particularly in New York City. Some staff visits were announced, others were unannounced. Some observations were made with the knowledge of the programs, others were made unobtrusively. Reports have also been received, both directly and indirectly, from the State Health Department, the Drug Abuse Control Commission and the Druq Enforcement Administration. Our finding is that while there have been sporadic deviations from the regulations, we know of no methadone program in operation at this writing, public or private, which is engaged in a wholesale violation of federal and state law to the extent of diverting large quantities of medication to numbers of buyers for a profit. We also believe it necessary to question the basic premise of widespread methadone diversion in New York City.

Although the issue of methadone diversion has been publicized in the media, to the point that most people tend to accept it as fact, all roads along the diversion trail lead to statistics published by the Acting Chief Medical Examiner in New York City regarding so-called methadone related deaths. The controversy over methadone death statistics is well known. On November 10, 1972, then Chief Medical Examiner, Dr. Milton Helpern, denied the validity of statistics issued by his own office, and on July 21, 1974, Dr. Helpern, now retired, was quoted by The New York Times as declaring those statistics the output of "an overzealous

assistant in his office who was eager to discredit methadone".

Despite Dr. Helpern's candor, the controversy has not ended. We believe that the reason for this is the absence of published criteria for determining when a specific drug may be validly reported as the cause of death. In August of 1974, the Medical Examiner's Office issued new statistics. The New York Times, which usually takes great pains to see that its headlines are supported by the story content, bannered the message that methadone deaths in 1973 were double those of heroin deaths in the same year. The story, however, raised some other interesting points, both of fact and of omission:

• All narcotic deaths were down twenty-five percent. Most officials believe the overall reduction is attributable to the accessibility of treatment programs, particularly methadone maintenance clinics, which treat over thirty-three thousand addicts, as opposed to abstinence programs, which treat perhaps two-thirds as many persons, relatively few of whom are now true narcotic addicts.

• The Medical Examiner did not state, nor did The Times inquire into the specific circumstances of the one hundred eighty-one deaths directly attributed to methadone. As witnesses frequently testified during Commission hearings, three ounces of lead introduced at high speed into the cerebral cortex of a methadone abuser is as likely to result in death as the presence of methadone.

• The statistic of one hundred eighty-one deaths (even if valid) out of an in-treatment population of thirty-three thousand

and an untreated population estimated by Dr. Vincent Dole to be as high as seventy-thousand, reveals a problem to be further diminished, but hardly one so calamitous as to invite the attention it received.

This continuing controversy in the New York City Medical Examiner's Office leads the Commission to recommend an expansion of the authority of the New York State Department of Health to investigate and monitor the development of statistics by the Office, as well as those throughout the state.

Let us assume, however, that a certain amount of methadone is currently being diverted, whatever the actual statistics.* The question remains as to why any methadone is being diverted and whether private programs are more likely to be sources for such diversion than public programs.

Compared to heroin, methadone is a long-acting drug. Patients stabilized at one hundred milligrams per day do not usually experience any significant effect from heroin taken in tandem with the methadone. However, the amount of methadone needed to prevent withdrawal symtoms can be reduced to considerably less. The methadone patient who no longer craves heroin and is, therefore, not fearful of a relapse, may be able to use only a portion of his methadone and

* Police arrest statistics tend to indicate only a willingness of some persons in programs to sell small quantities of methadone to undercover agents posing as addicts feigning withdrawal. They do not indicate the actual number of non-police induced sales, nor do enforcement authorities perceive organized distribution efforts.

sell the rest. The patient who desires simply to lower his tolerance to methadone in order to achieve some sensation from heroin, may sell some of his methadone to purchase heroin.

The purchase of heroin by methadone patients is not unknown; but it is usually detected by the presence of morphine or quinine in the urine. At a time when heroin of good quality is rarely available in significant quantities, methadone patients who are experiencing difficulty in adjustment or resocialization tend to turn to non-narcotic drugs, such as tranquilizers and alcohol. While some tranquilizers, such as barbiturates, are detectable by routine analysis, others are not, and the program must rely on the absence of methadone in the urine and the demeanor of the patient to detect the existence of a problem. The fact that a methadone patient may be using other drugs does not usually indicate that he is selling his methadone. He may either be taking other drugs in addition to the methadone, or he may simply be discarding the methadone.

The misbehavior of a methadone patient is, in most cases, attributable to three causes. First, most methadone patients are gainfully employed. The resocialization of methadone patients tends to be far more rapid than that of narcotic addicts in other types of programs. The absence of work, on the other hand, is a severe impediment to rehabilitation, particularly for methadone patients. For these patients methadone is not the substitute "high" in place of heroin addiction, since stabilized methadone patients seldom feel euphoric on their medication; rather, work: achieving at a

job, becomes the substitute "high". Methadone patients at work are industrious; they frequently have good morale; and they usually relish their new found feelings of importance.* Without work, the temptation to return to old habits, or variations thereon, may seem irresistible. The importance of constructive activity for methadone patients requires emphasis, because this treatment modality, regardless of the number of counselors employed, does not by its very nature restructure character through confrontations and live-in situations.

Oddly enough, it is often not the public methadone programs which support a work ethic, but the private programs, and, to a lesser extent, the voluntary programs. In depth interviews with staff members of Drug Abuse Control Commission multimodality programs and with New York City Methadone Maintenance Program personnel revealed a sense of hopelessness, a hopelessness that is communicated to their clients, regarding ultimate job placement for as many as ten percent of the addicts now in treatment. Their theory is stated both in psychological and in political terms. Some addicts have only enough ego strength to stop using drugs. To expect them to become constructively occupied is simply expecting too much. Moreover, so the political end of the argument goes, if a percentage of non-addicts have a right to do nothing and collect welfare, why should all addicts be expected to work?

The Commission finds these arguments to be specious. Every respected authority in the field of education, psychology

*We have appended to this report the results of a carefully controlled employment project at Equitable which bears out these statements.

and human behavior shares the view that people normally have a need to feel productive. Understanding the full range of educational and vocational requirements of addicts, as well as each addict's unique situation and potential, calls for the professional expertise of experienced vocational rehabilitation counselors. Understanding the job market and how to place rehabilitated addicts, how to develop employer trust, and how to help the rehabilitated addicts to adjust to a job situation is the role of tough-minded job placement workers. Of course it is easier to hire a psychologist, who can invent reasons for doing nothing, than to hire vocational experts who will keep the entire program on its mettle. Of course it is easier to hire counselors who cannot distinguish between dead-end training programs and programs leading to genuine opportunities, because such counselors can always blame the addict for ultimate rehabilitation failure, rather than blaming the shortcomings of their own program. It has been said, "Drug addiction is a chronic relapsing syndrome". This formulation can and has been used as a pretext for pessimism, inaction, and resistance to evaluation. Relapses among working, recovered addicts are infrequent. Creating the anticipation of relapse, for the employer or for the rehabilitating addict, invites not only complacency and incompetence of staff personnel, it invites the self-fulfillment of a cynical prophesy.*

Despite this sharp criticism, as we did in our report entitled, Employing the Rehabilitated Addict, cited above, we again wish to call attention to the excellent work being done by

* "A Perspective on Vocational Rehabilitation Planning" Erie County Division of Addiction Services, July, 1974.

the Nassau County Drug and Alcohol Addiction Commission, which continues to give the lie to the view that because an addict has not worked out on one job or because he has failed to complete one training program, he should be abandoned to welfare and medication for the rest of his life. We also applaud the innovative approach of the Long Beach Memorial Hospital Drug Program. They denominate their effort as an attempt to "resocialize" patients. The emphasis tends to be one-on-one counseling, not with reference to character restructure, but with reference to helping patients identify coping skills needed in social and work situations. One of their techniques is the use of the hospital, itself, as a training ground for rehabilitating addicts.

A general hospital maintains a cross-section of employment opportunities. Instead of referring all individuals to training programs at the North Shore Hospital, some of which are alleged to set unrealistic goals, the Long Beach staff uses its hospital to help patients adapt to a variety of working and learning situations. A number of rehabilitating addicts participate in hospital functions, both on a paid and on an unpaid basis. This approach is highly regarded by the hospital's own administration. It also appears to have promise with regard to polydrug abusers, who can be counseled professionally while they work in a supervised and structured environment. This theme will, therefore, recur in the forthcoming discussion on abstinence programs.

Turning to profit-making programs, the charge is heard that because profit-making programs receive Medicaid reimbursement

for indigent patients, the taxpayers contribute to such profits, which inflate in inverse proportion to the services allegedly denied patients. Medicaid was designed, in part, to induce upper income practitioners to attend indigent patients. There was never any question that Medicaid should apply only to public and non-profit services. The average payment by a working addict to a private clinic is twenty dollars per week. The average reimbursement authorized per visit by Medicaid is six dollars, although pending the outcome of current litigation, New York City approves only four dollars per visit for profit-making programs. A voluntary agency, such as Beth Israel, which provides full back-up care to a number of clinics, receives reimbursement at the rate of over fourteen dollars per patient visit. The Health Services Administration of New York City receives over seven and one-half dollars per patient visit. In terms of dollars and cents, working addicts in private programs subsidize a portion of the total cost of care for indigent patients in such programs. The requirements of services under federal and state regulations and the limitations on the number of patients to be treated at any one facility, reduces the argument about inflated profits to its proper perspective. Moreover, since as many as one-third of the patients in private programs are on Medicaid, great emphasis is placed upon rehabilitation via employment and job training. It stands to reason that a higher percentage of profit-making clinic patients are gainfully employed than are patients in public programs.

The Commission staff asked a number of patients in pri-

vate programs why they continued to pay for treatment they could receive for nothing at public or voluntary programs. Although some patients cited the convenience of a particular location, such as the docks near the Red Hook section of Brooklyn, where one rehabilitated addict works, and some cited the hours the clinic was open, most of the patients expressed a feeling of pride in being able to pay their own way. A few were cynical, even embittered about their course of rehabilitation. The majority, however, felt closer to normality than they had ever been in their lives.

Rather than raising questions about the public interest in maintaining private programs, the Medicaid-profit controversy raises disturbing questions about the operation of public and voluntary programs. The Commission has been informed officially that no payment is ever sought from working patients in voluntary programs, such as those operated by Beth Israel, and in those operated by New York City. The total cost of methadone programs in New York State is over fifty-five and one-half million dollars. Of this total, approximately ten and one-half million dollars is allocated for private patient reimbursement. The rest is unrepaid outlay for thousands of patients, many of whom are working and could be reimbursing the government, rather than receiving free treatment. At a time when the high cost of medical care to all citizens is a matter of serious concern, any unwarranted largesse to addicts must be carefully reappraised.

The cost analysis of methadone is as follows:

$42.6 million (Organized contract programs)

$14.4M State
(50% federal)
18.7M Medicaid (25% state)
(25% local)
9.5M Local governments and other sources

2.5 million (State-operated facilities - 50% federal
50% state)

10.5 million (Private practitioners)

$55.6 million

(See chart on following page for Medicaid reimbursement rates.)

If, conservatively speaking, ten thousand of the patients currently at work and on methadone were permitted to pay ten dollars per week, the state could reduce the cost of methadone treatment by five million dollars per year. If an additional five thousand patients were willing to pay twenty dollars per week for their treatment, the state could save still another five million dollars. The catch is, of course, that even if the patient wishes to pay, he is systematically discouraged from doing so. The worst incident along these lines involved a patient in a private program, who was working, and who transferred to a public program when his private program relocated. He asked whether he could pick up his methadone either at seven in the morning, before starting work at eight, or in the evening. He was told that such arrangements were impossible, and if he could not manage, he should quit his job and apply for Medicaid.

The Commission recommends the following:

1. The Drug Abuse Control Commission should gather together from the State Department of Health, which administers Medicaid, the State Department of Social Services, and its own programs materials necessary to audit any and all outlays of state funds for the care of drug addicts and drug abusers capable of providing some payment for the services they receive.

CHART

1974 MEDICAID RATES

	Per Visit
INDEPENDENT OUT OF HOSPITAL HEALTH FACILITIES:	
New York City Region:	
Addiction Research & Treatment Corp.	$ 6.20
Albert Einstein College of Medicine - M.M.T.P.	11.83
Albert Einstein College of Medicine - M.C.D.P.	16.44
Health Service Administration of New York	7.64
Western New York Region:	
Community Action Organization of Erie Co., Inc.	11.96
Lackawanna Comm. Health Ctr. - M.M.T.P.	10.30
Northeastern New York Region:	
Albany County Health Department M.M.T.P.	7.70
Northern Metropolitan Region:	
Ulster County Drug Comm.	9.76
Long Island Region:	
Nassau County Health Department Drug & Alc. Add.	12.00
Suffolk County Narcotic Addiction Control	11.00
HOSPITALS:	
New York City Region:	
Beth Israel Medical Center M.M.T.P.	14.69
Brookdale Hospital Medical Center M.M.T.P.	9.03
Mt. Sinai Hospital M.M.T.P.	10.90
Western New York Region:	
Sisters of Charity Hospital M.M.T.P.	5.86
Northern Metropolitan Region:	
Mount Vernon Hospital M.M.T.P.	6.98
Northern Westchester Hospital M.M.T.P.	5.39
Peekskill Hospital M.M.T.P.	5.62
St. Joseph's Hospital, Yonkers M.M.T.P.	7.00
St. Luke's Hospital of Newburgh M.M.T.P.	5.13
Westchester County Medical Center (formerly Grasslands Hospital) M.M.T.P.	5.10
White Plains Hospital M.M.T.P.	5.65
Yonkers General Hospital M.M.T.P.	6.00
Long Island Region:	
Long Beach Memorial Hospital M.M.T.P.	6.72
Central New York Region:	
St. Joseph's Hospital, Syracuse M.M.T.P.	16.33

2. Without engaging in aggressive collection procedures, non-profit drug treatment programs should provide a simple, onging and direct method of encouraging the weekly payment of fees from working patients. Since sliding-scale fees are difficult to administer, we recommend the establishment of low, flat-rate fees, such as three dollars for every fifty dollars of take-home pay.

3. Regulations of the Drug Abuse Control Commission should require each methadone clinic to be open long enough in the early morning or in the evening to permit working patients to pick up their medication without calling attention on the job to their need to do so.

4. The federal government should permit one clinic attendance per week instead of requiring two, for persons stabilized on methadone longer than one year (instead of two) in order to enhance the likelihood of their obtaining and holding jobs.

Since even a methadone patient bent upon selling his drug will probably drink a full daily dose at least twice a week, to prevent withdrawal, the extra mid-week visit for the most reliable group of patients seems superfluous.

Rehabilitation workers have told the Commission that patients in methadone programs who exhibit problems, such as diversion of drugs or polydrug and alcohol abuse, do so for three reasons. The first was lack of constructive activity, particularly lack of work. Not all activity to occupy rehabilitating addicts need be work or therapy, per se. Rehabilitating addicts, it has been shown, are more successful when provided wholesome recreational outlets, such as trips to athletic events, theater parties,

and bicycle outings. Even the provision of game rooms may be advisable in certain neighborhoods in which the inactivity of the addict for most of the day may result in indecorous confrontations with neighbors of the treatment program. The Commission, therefore, recommends the inclusion of recreation components in methadone treatment programs.

In light of the importance of employment, the Commission takes no issue with the regulation of the Drug Abuse Control Commission requiring one vocational counselor for each one hundred fifty patients, subject to reasonable exceptions. However, since the Drug Abuse Control Commission is empowered to make exceptions regarding staffing and frequency of clinic visits, and since complaints abound regarding the rigidity of the current exception mechanism, we recommend the establishment of an advisory committee, comprised of providers of treatment, as well as D.A.C.C. officials, to guide as well as expedite decisions in this regard.

Another of the problems that has come to our attention as a source of patient disequilibrium in methadone programs, is pressure upon the patient to detoxify from methadone prematurely. Rather than tethering patients for the purpose of exploiting them, a number of programs, both profit-making and non-profit, either encourage premature detoxification or they fail to discourage such inappropriate behavior.

One of the factors which places pressure on both the patient and the program to move towards premature abstinence is community antipathy to methadone. Some of this antipathy is based upon a disbelief in the efficacy of this modality of treatment.

There is strong evidence, particularly in terms of reduced crime, of the salutary nature of drug treatment. Moreover, although much opposition to it is framed in terms of criticism of profit-making programs, because some of the best programs in the State, such as several visited by the Commission staff, show a profit, leading experts in the methadone field, including the Directors of the largest public and voluntary programs, believe that opposition to private clinics is simply opposition to methadone as a treatment modality.

This opposition takes a grave toll among patients. Families, employers, and friends frequently coax, cajole and threaten patients with loss of social acceptance if they remain on methadone. The patients, themselves, begin to feel as if they are second class citizens. This feeling is even reenforced by programs which have an explicit methadone-to-abstinence philosophy. The result of this pressure is that addicts leave treatment prematurely, or they become polydrug abusers, or they fail to enter treatment when it is available. These persons then create the very market for illicit methadone sought to be discouraged.

Experts believe there is all the difference in the world between an explicit philosophy of methadone-to-abstinence, and an implicit but ultimate goal of abstinence. After one or two years, most methadone patients ask for a reduction in medication. Some of them are able to be withdrawn successfully by a gradual regimen lasting, in some cases, as long as two years. Others, particularly long-term heroin addicts, feel uncomfortable if

much of the methadone is withdrawn. One theory, espoused by Dr. Dole, is that patients who begin to feel uncomfortable during a gradual withdrawal from methadone may have to remain on the drug for the rest of their lives, not because methadone is more addicting than heroin, but because their heavy and prolonged involvement with heroin resulted in an as yet undifferentiated biological imbalance. Whatever the reasons, some methadone patients are resigned to life-long use of the medication, while others seek to be withdrawn, and are withdrawn successfully. In either case, however, the patient well stabilized on methadone or successfully withdrawn will perform indistinguishably in social or employment situations from anyone else. Many rehabilitation workers believe that no patient on methadone should be the subject of instigation by others to discontinue his medication. "When he is ready for detoxification, he will let his counselor know".*

The third source of difficulty in methadone rehabilitation derives from untreated physical and emotional illnesses. We do not mean to suggest a simplistic cause-and-effect relationship between emotional illness and drug abuse: The presence of concurrent, tangentially related symptoms in medicine is well known. However, such untreated illnesses do exacerbate problems already inherent in the rehabilitation process. It is in regard to untreated physical and emotional problems that profit-making clinics must take the heaviest share of responsibility.

*Dr. Harold Trigg, Clinical Director, Methadone Maintenance Programs at Beth Israel Hospital, New York City.

A great many patients transfer from private programs to non-profit programs for a variety of reasons. When these patients are examined, they are often found to be suffering from serious physical ailments, including organic deterioration attributable to alcoholism. In order to open free-standing clinics, a private physician must obtain an affiliation agreement with a hospital in the vicinity to provide back-up services. Dr. Arthur Zaks has alleged that certain hospitals are willing to accede, pro forma, to such agreements, for consideration, with the expectation by both parties that physical and psychiatric care needed by methadone patients will be supplied spontaneously or on an ad hoc basis by public and voluntary agencies. A physician associated with a well-reputed private program confessed that he did not know the name of his own affiliated back-up hospital, and that he has been consistently unable to obtain needed physical and psychiatric care for patients from public or voluntary agencies.

The Commission recommends that the State Department of Health suspend all Medicaid reimbursements to any program, public or private, whose support services are blatantly non-existent.

Dealing with the emotional problems of addicts in treatment, who do not require care in a separate facility, raises the issue of professional versus experienced paraprofessional counseling. This issue will be discussed at greater length in

our chapter entitled, "Abstinence Programs: Prohibition Is Not Enough". However, a few brief observations are in order in this context.

When the heroin problem appeared to be reaching epidemic proportions in this state, most professionals in the mental health field believed themselves unable to assist addicts, whose presenting problem, addiction, was not amenable to orthodox intervention. The tendency of addicts to be totally engulfed by heroin: achieving euphoria, preventing withdrawal, hustling the price, and resisting treatment, led most concerned citizens, including health and mental health professionals, to view the problem as more suitable for the criminal justice system than for the psychiatrist's office. Addicts simply did not look like typically emotionally disturbed clients. Thus, many psychiatrists, psychologists and social workers shied away from treating addicts. Others, who approached addicts in terms of classical therapeutic modalities, had disastrous results.

The people who seemed to relate best to addicts were other addicts who had somehow reformed themselves, or who had received the first experimental maintenance dosages of methadone, or who were participants in newly created rigidly disciplined therapeutic communities. Because of the unavailability of professionals in significant numbers, most initial treatment procedures tended to screen out patients with histories of severe personality or emotional disorders. The first addicts admitted to treatment tended to be highly motivated, and were often able

to coordinate their own back-up and support services. A methadone patient might, for example, report to his counselor that his ability to work had enabled him to afford psychotherapy; or that his ability to function on methadone had eliminated nearly all of his preexisting anxieties and behavioral indiscretions, so that no additional help was needed.

As greater numbers of addicts entered treatment, those professionals assigned to help them, or to supervise others counseling them, were further alienated by the extensive differences between themselves and the addicts, in terms of their own previous training, their own expectations of patient amenability to treatment, and their own subcultural predilections. "It takes a great deal of time for a white, middle-class social worker to learn how to deal with the problems of a Black youngster who is in serious trouble, but who perceives his social worker as part of the cause of that trouble. Some professionals simply gave up. Others adopted disrespectful attitudes, such as the view that poor people are unwilling to work at anything, including their own rehabilitation".*

Those professionals who remained in the field and were honest with themselves and their clients ("New Ways of Treating Addicts", Social Work, July, 1974), began to see two developments. First, certain classical approaches did begin to yield results. This was particularly true of patients in methadone maintenance programs, who, like poorly functioning or disorganized non-addicts, became amenable to the same kinds of help for the same

*Lucy Freeman, C.S.W.

kinds of reasons, once the craving for illicit drugs had been eliminated by the use of methadone. The second development was the entrance into treatment of greater numbers of addicts with accompanying emotional and personality problems, because of the advent of greater numbers of available treatment slots. These two developments have now made it possible to speak realistically of a need for professional mental health services in the treatment of addiction, at the same time that it is now becoming possible to meet that need. Initially, contact with addicts may still require the nonprofessional touch, particularly of a counselor in the same age group or ethnic category as the addict. If rapport is good, such counselors may continue to help their clients under close professional supervision. There are problems, however, which are of such complicated dimensions, involving domestic relations, emotional symptoms and community resources, that the professionals should deal with these directly. We call upon the Drug Abuse Control Commission, therefore, to inquire of treatment programs throughout the state the feasibility of providing formal psychiatric, psychological and social work evaluations and treatment of clients requesting such services, either through meaningful liaisons with community providers of such services or through the incorporation of such services into treatment programs, themselves.

LAW ENFORCEMENT

The New York State Controlled Substances Act provides for a methadone patient reporting requirement from the treatment programs to the State Department of Health, as one control against fraudulent admissions. By agreement between the State Department of Health and the Drug Abuse Control Commission, D.A.C.C. assumed full responsibility for treatment program compliance, including the maintenance of a central registry of addicts. Data is provided by D.A.C.C. to the State Health Department, which has the primary responsibility of controlling against methadone diversion.

The Controlled Substances Act also requires that methadone programs report the quantities of medication received and dispensed. Initial compliance was slow, with ninety-eight programs delinquent. By July of 1974 only twenty-three programs had failed to report, and these were being closely watched. Only minor discrepancies have been noted between the quantities of drug received and those dispensed, although several robberies have occurred.

The State Health Department reports the following disciplinary actions:

(1) Elio Maggio, M.D. - upon investigation and referrals indicted by federal grand jury for illegal sale of methadone maintenance treatment program director

(2) Robert Dale, M.D. - investigated and now fugitive from justice; former methadone maintenance treatment program director

(3) Rafiq Jan, M.D. - Investigated New Drug status removed by Food and Drug Administration following major irregularities in methadone maintenance treatment program operation as a result of joint investigation by Food and Drug Administration and the Department*

(4) Evaldas Deckys, M.D. - medical director for a proposed methadone maintenance treatment program; arrested following Departmental investigation of illegal sale of narcotics

In addition a non-physician who aggressively promoted the establishment of a methadone program was also investigated. His name is Robert Kottner, a real estate operator, about whom a B.C.I. report indicated a criminal history, involving grand larceny and related offenses and establishment was denied.

During the past year and one-half, the Department initiated action against the Alan Kaye, M.D., M.M.T.P., 1001 Fox Street, Bronx, New York, because of improper dispensing practices, improper labeling, and failure to maintain proper records. The charge was settled by a formal reprimand.

Action was also initiated against Eugene Silberman, M.D., M.M.T.P., 306 East 11th Street, New York, New York because of alleged hidden ownership of the clinic, and inadequate counseling service. However, the charges were dropped and the sponsor was allowed to relocate on the formal condition that the program would voluntarily cease operation if it was subsequently found in violation by the Department. The temporary narcotic license of Harold Reilert, M.D., M.M.T.P., c/o Promethean Society, 5 Jane Street, Franklin Square, New York, was not extended because in consultation with D.A.C.C. we determined that the sponsor had not corrected numerous violations of state and federal rules on methadone.

The Drug Abuse Control Commission is currently in the process of establishing four investigation teams for the purpose of exacting program compliance. The Chairman of D.A.C.C. reports that at least two potentially unreliable programs have been discouraged from opening by pointed allusions to the new D.A.C.C. regulations.

*Note: A new federal law permits the Drug Enforcement Administration to take direct action, without prior approval of the F.D.A.

The New York City Police Department reports that felony arrests for methadone decreased from two hundred seventy-four between January and June of 1973 to one hundred nineteen between January and July of 1974. The total number of Narcotics Division felony arrests during the same 1974 period was one thousand seventy, so that methadone felony arrests reflect but one-tenth of all narcotic felony arrests. Cocaine and heroin arrests far outnumber those for methadone.

In other parts of the state, hearings in Buffalo, Syracuse, Poughkeepsie and Nassau, as well as spot-checks in Rochester, Schenectady, Binghamton and Suffolk Counties revealed either extremely small or non-existent problems of methadone diversion. The numbers of arrests are statistically insignificant.

Moreover, diligent inquiries by the Commission staff have failed to uncover more than two individuals recently admitted to treatment programs as primary methadone addicts, whose addiction eventuated from street sales.

Although the extent of methadone diversion is controversial, the practical question remains of how to handle a patient suspected of selling his drug. Since the present penalty structure is currently under litigation, we reserve comment on the subject of appropriate penal sanctions and will present, herein, the recommendations made to the Commission by Dr. Alfred S. Howe, Director of the Suffolk County Drug Treatment Services on the medical approach to a patient who may be diverting his methadone. Testifying at our hearing in Mineola,

Long Island, on September 5, 1974, Dr. Howe said that the first step would be to curtail or eliminate all take-home privileges. In the event that the patient continued to be uncooperative in treatment, other modalities should be considered. If the patient were not eligible for any other treatment modality, and persisted in untrustworthy behavior, he should be detoxified and dropped from the program.

RECOMMENDATIONS

Methadone maintenance is an effective treatment modality for the rehabilitation, resocialization and vocational adjustment of hard-core heroin addicts. Unbiased multimodality providers of treatment report greater employability and less recidivism among methadone patients than among any other similar groups of rehabilitating addicts. The Commission makes the following specific recommendations to improve the status of these patients:

1. In light of the controversy over methadone death statistics in New York City, the Commission recommends an expansion of the authority of the State Health Department to investigate and monitor the operation of the New York City Medical Examiner's Office, particularly with regard to its development of statistical data. Such authority should also extend to other Medical Examiners' Offices throughout the State.

2. There is a need to promote employment among rehabilitating addicts in methadone maintenance programs. The Commission

endorses the requirement of the Drug Abuse Control Commission that one vocational counselor be retained for each one hundred fifty patients. We invite the attention of providers of treatment to the excellent work being carried on in this field by the counselors and job placement workers at the Nassau County Drug and Alcohol Addiction Commission. We believe serious consideration should also be given to the study of such programs as that at Long Beach Memorial Hospital, with a view toward utilizing openings in hospitals, themselves, as structured vocational training slots.

3. We find that the use of public funds to provide free methadone treatment to working patients who can afford to repay some of the cost of that treatment is counterproductive.

(a) We call upon the Comptroller of the State to audit state outlays of funds, including Medicaid reimbursements, for patients capable of assuming a portion of the cost of their own care.

(b) Without engaging in aggressive collection procedures, non-profit drug treatment programs should permit their working patients to contribute a flat-rate weekly fee, such as three dollars per fifty dollars of take-home pay. In this way, the State could reduce the annual cost of methadone maintenance by upwards of five million dollars.

4. Methadone programs should provide greater recreational outlets for patients, to discourage indecorous confrontations with neighbors of such programs. Community leaders should work along with methadone programs to overcome problems of ob-

jectionable conduct by patients. Each facility should maintain an observation of the behavior of its clients in the neighorhood.

5. To enhance the employability of rehabilitating addicts, the present federal requirement that persons in treatment for longer than two years must report to a clinic at least twice a week should be changed to at least once a week after one year.

6. The Drug Abuse Control Commission should consider a more specific regulation that methadone clinics open early in the morning or during the evening to permit working patients to pick up their medication without calling attention on the job to their need to do so.

7. Complaints about the rigidity of the current mechanism for granting exceptions to D.A.C.C. methadone regulations have led us to recommend the establishment of an advisory committee, comprised of providers of treatment, as well as D.A.C.C. officials, to advise as to measures to expedite decisions in this regard.

8. The State Health Department should suspend all Medicaid payments to methadone clinics, especially profit-making clinics, which are unable to provide actual meaningful back-up medical and psychiatric care.

9. The Drug Abuse Control Commission should inquire of treatment programs throughout the state as to the feasibility of providing formal psychiatric, psychological and social work evaluations and treatment of clients requesting such services, either through meaningful liaisons with community providers of such services, or through the incorporation of such services into treatment programs, themselves.

CHAPTER II

ABSTINENCE PROGRAMS: PROHIBITION IS NOT ENOUGH

As we indicated in our report entitled, Drug Abuse Prevention (Legislative Document No. 11, 1974), prior to our national period of Prohibition, alcohol was not a proper subject of humor. Its acceptance was surrounded by Victorian imprecations, sometimes motivated by class-consciousness, but more often impelled by alcohol's exacerbation of problems associated with hazardous industrial conditions and unhealthy housing. The repeal of the Eighteenth Amendment by the Twenty-first Amendment in December of 1933, only ten months after the repealer's initial proposal, signaled a new, more realistic, but perhaps more indulgent, attitude towards alcohol in the United States. Less than two years later came the founding of an organization known as Alcoholics Anonymous.

Twenty-three years after the founding of A.A., one of its members led the organization of the first therapeutic community for drug addicts (Synanon). Although certain differences to the A.A. approach were built into the t.c. program, the dynamics of A.A.. which had never been satisfactorily explained, were thought to provide a certain potential for treating drug addiction. That A.A. works for some alcoholics was known. That A.A. works subsequent to the failure of mental health professionals to reform

certain alcoholics was also known. Since most mental health professionals then regarded addicts as "incurable", the timeliness of an experimental approach using reformed addicts to help rehabilitating addicts, on the basis of an experience of using recovered alcoholics to lend in the recovery of drinking alcoholics was clearly established. Need overwhelmed niggling doubts regarding whether the underlying concept of A.A., never made explicit, was transferable to drug addicts.

Although no individual or policy group speaks for A.A., they do have a certain informal leadership. That leadership is comprised of persons whose views on alcoholism could, conceivably, be precisely the opposite of the very dynamic that explains the success of A.A. Those views tend to side with the thesis that alcoholism is not caused by mental illness or prolonged drinking, but rather, is a disease that strikes at only a certain percentage of the drinking population. Having identified themselves as afflicted with the disease, they simply strive to make alcohol as irrelevant to their social diet as a person with an allergy to feathers would strive to make swansdown irrelevant to his sleep. The most successful members of A.A. tend to give the impression that their avoidance of alcohol has become casual, even cavalier.

It is possible, however, that the success of A.A. is based upon zeroing in on the very liquor that destroys them. By focusing all of their guilt upon alcohol, since 1933 a drug presented almost always as a source of pleasure, they can provide

themselves with a source of permanent expiation through self-denial: not the self-denial borne of one clear decision made at a single A.A. meeting, but the self-denial borne of myriad opportunities and temptations. Perhaps that is why repeated reenforcement through attendance at meetings is considered so important to continued abstinence.

For the drug addict, the label of sociopathy, or at least functional sociopathy, has been so often applied, we forget that even sociopaths may feel some guilt. Since heroin is not only a source of pleasure, but by its illegality and inherent dangers, and its romance with the needle, more frequently a source of punishment, abstinence, in and of itself, may not be enough to deal with guilt. Because of the availability of alcohol, an alcoholic can remain oblivious to external stimuli for weeks, sometimes months. A heroin addict can remain oblivious to external stimuli only until his source of the drug is interrupted. Return to drug abuse, then, is not only an indulgence in deviance and pleasure; it suggests a painful motif for the person with little or no self-esteem. Many guilty alcoholics can achieve their psychic pain through abstinence; the guilty heroin addict can achieve his pain either through abstinence or drug addiction. Since he can also achieve a certain amount of pleasure through drug use, to retain him in a drug-free program, a high degree of motivation is necessary, derived from within himself or imposed from without by law enforcement and correctional agencies.

The Synanon experiment established four basic principles:

1. Self-help. Only an addict can understand and cure an addict.

2. Drug-free. Chemicals are not helpful in the rehabilitation process.

3. Honesty. Only with the brutally honest expression of feelings about each other are members of the community able to abandon their self-defeating and self-destructive images.

4. Utopia. The general community is sick. A microcosm of a putative healthy community is to be the goal. Patients may choose never to return to the general community, but people at large may seek to transform society as a whole into a macrocosm of the therapeutic community.

To cope with the pleasure-pain attraction of heroin, therapeutic communities adopted rigid organizational structures marked by authoritarian hierarchies. The object was to treat the addict as immature and in need of developing good judgment, with regard to personal habits and, especially, in attitudes towards authority. As good judgment developed, status and privileges would be increased, until the patient assumed control over an area of t.c. life and thus became part of the governing hierarchy. Until such point, the resident had no personal responsibility for decisionmaking without direct and immediate guidance and control. As in an authoritarian state, there could be no personal guilt because there was no personal latitude.

Although the rate of premature terminations was always high (at least fifty percent within the first three weeks of treatment) and although the rate of "graduation" was always low (between two and fourteen percent), it was not until the late 1960's and early 1970's that evidence began to mount indicating therapeutic communities were in deep trouble. That evidence took the form of evangelical campaigns* by heads of programs: (1) to achieve a recriminalization of drug abusers, particularly with a view towards returning absconders by force; and (2) to destroy the credibility and the viability of the more attractive and behaviorally more successful methadone programs. By 1974, leading therapeutic communities were under investigation for inflating their census to justify public financing, for attempting to treat non-addicts, and for failure to deliver services promised in contracts with funding agencies. Even the highly regarded Phoenix House complained to this Commission that its decreasing retention rate was making its treatment strategy unworkable. Later, Phoenix broadcast an S.O.S. through the media that it would be willing to house virtually any friendless person, addicted or not, to keep up its census.

In December of 1973, a report to the New York City Addiction Services Agency by Systems Sciences, Inc. revealed an extraordinary account of the failure of most of the twenty-four therapeutic communities surveyed. Since the Synanon experiment, therapeutic communities had developed by branching out into differing strategies, while attempting to preserve some of the fun-

*See Glaser, F.B., M.D., "Some Historical Aspects of Drug-Free Therapeutic Community," American Journal, Drug & Alcohol Abuse, 1(1), pp.37-52(1974).

damentals of Synanon.

Long-term programs were supposedly geared to character restructure. Some, like Phoenix House, remained fairly close to the Synanon model. Others, like Odyssey House, tended to develop along lines of treating drug addiction as a symptom of underlying emotional disorders. The Alpha School and Exodus House stressed educational and vocational training. The NARCO programs, among others, followed short term, local adaptational models.

Using the Systems Sciences report as a starting point, the New York City Addiction Services Agency began evaluating all drug-free communities in New York City. Of those t.c.'s mentioned in the System Sciences Report, Compass, Daytop, Exodus, Inward House, Quaker Committee, Queens General Hospital and Samaritan Halfway Society were found to be valid, useful programs. Other abstinence programs praised by ASA included Boy's Harbor, E.S.P.A.D.A., Mount Sinai Hospital, Reality House I, Greenwich House, The Door, Project Return, V.E.R.I.T.A.S. I, Seaport Pioneer Program, Riverdale Mental Health Clinic, Downstate Medical Center, Dynamite Youth Center, Midwood Adolescent Project, Canarsie Youth Center, and Samuel Field YMWHA.

One of the excuses given by abstinence programs which have closed recently and those currently under investigation for failure to contribute to solving the drug problem has been the changing nature of the drug problem. Abstinence techniques, such as confrontation and gradual improvement in status, are said to have worked with true heroin addicts, but are not successful with

today's polydrug abuser. A serious question exists however, as to whether the original drug-free concept ever really succeeded. It was pointed out that these programs derived their impetus from Alcoholics Anonymous. Although A.A. has been in existence for nearly forty years, and despite the increasing number of alcoholics in the United States (between nine and fifteen million), A.A. has only two hundred fifty thousand members nationally. Abstinence programs for drugs always recognized that they could help only a small percentage of the addict population, but statistics even among those who remained in treatment were never very promising. At its optimal level of operation, Phoenix House reported that over twelve percent of its residents were heavy alcohol abusers while in treatment (Phoenix House, Who Comes For Treatment, December, 1972). The therapeutic communities steadfastly protest that their residents are all free of drug use while in the program. Most have equally steadfastly refused to require the same periodic urinalysis mandated by federal and state law for methadone programs. D.A.C.C. multimodality programs which require urinalysis report a greater incidence of drug abuse in their own "drug-free" programs than in methadone programs. Has this not always been the case?

Except for the few addicts who were able to use their own abstinence in the same way recovered alcoholics do, and except for those addicts who found a refuge from the real world within the authoritarian structure of their program, and who have remained in the drug field ever since their graduation, success was always

ephemeral. Methadone programs teem with abstinence program drop-outs. Prisons and jails have been filled with those who absconded after a few weeks from drug-free programs. Aside from the conceptual non-transferability of the self-imposed prohibition of A.A., two other major defects may be responsible for pinpointing both the success of the few abstinence programs commended by ASA and by this Commission, as well as the failure of the rest.

Some of the observations made by the Commission staff upon a recent visit to the Hart Island facility of Phoenix House may indicate what one of the problems of the typical abstinence approach may be. Despite the relaxation of some of the more grotesque house rules (residents in poor standing are no longer required to shave their heads or wear placards reciting errors in conduct), the totalitarian* structure of the program is both philosophically and practically unrelated to the structure of society. Moreover, there appears to be a strong prejudice against blue collar work. This prejudice is reenforced by exaggerated expectations of success to be derived from the achievement of a high school equivalency certificate, as well as by the use of menial tasks as a system of punishment and reward. Work in the community is discouraged until the individual is "ready". The theory is that the resident is going through "changes". This means that his character is being restructured. Should he accept work that is unsuitable or be rejected for the job of his choice, he might

*The word "totalitarian" is freely used in this context by staffs of therapeutic communities, including Phoenix House.

relapse. This approach is in marked contrast to other modalities which stress interaction with the community through gainful employment and community-based training programs. If the treatment staff and unbiased observers do not view the operation of the program as a design for community reentry, then a reasonable inference must be that the resident who dropped out could not understand the relevance of what was happening to him, either. Perhaps there was none. (By way of contrast, the Herculean efforts of Daytop Village to reconcile its therapeutic community model with the need to prepare residents adequately for reentry is well known. Also well known is the extremely limited number of persons who can benefit from the rigors of a Daytop type of program.)

The most often-heard phrase in the context of successfully treating addicts is "the need to raise self-esteem". The second most often-heard phrase is "non-threatening atmosphere". Therapeutic communities, daycare programs and ambulatory treatment programs which originated along the classic Synanon model encouraged the "brutal honesty" of confrontation through group encounters. These encounters were designed to obstruct evasions and circumlocutions regarding personal conduct by confronting the patient with the underlying truth as inferred by more advanced patients. Since one patient's underlying truth is another patient's evasion, the dynamic was thought to work both ways: to cut through <u>all</u> rationalizations, and to bring each individual, as well as the group, as a whole, to confrontation with certain basic truths about human nature, or at least, about common

experiences.

The trouble with confrontation is that it works only under two exceedingly rare conditions: The client must view himself rather than the program, as a source of danger, and he must have the basic verbal and abstracting skills to come to terms with the group and with himself. Otherwise, he (or she) will view the process as threatening, and his (or her) inadequacy to relate to the process will result in a diminution, rather than a heightening of self-esteem. Moreover, the existence of any severe psychogenic or organic syndrome will serve to undercut the process via the well-known dynamics of mental illness.

The first attempt to venture beyond confrontation was conceptualized in terms of drug addiction as a psychiatric disorder or as a symptom of a psychiatric disorder. The remedy, as in the Odyssey House program, was to reinvent milieu therapy as an exponent of the Synanon model, and to reenforce environmental adjustment with individual and group psychotherapy. The flaw in this concept was that the only persons suitable for such treatment, assuming drug addiction is not simplistically related to psychogenic factors, would be persons whose primary diagnosis was not drug addiction at all, but mental illness, overlaid with drug abuse. In other words, the Odyssey House approach may have been unintentionally designed for those mentally ill persons who medicated themselves with illicit drugs, rather than for the majority of heroin addicts, whose emotional problems are related to drug

abuse, but not the primary causative factors. Complicating the Odyssey House picture have been repeated charges that even those psychiatric services promised to the few addicts and drug abusers who might benefit from them have not been fully delivered.

The Odyssey House experiment did, at least, point the way to the need for professional services beyond confrontation, whether or not such services have actually been furnished. Historically, therapeutic communities and other types of abstinence programs did not provide professional services. During the 1970's, the sheer humanitarian assessment of the needs of clients, the competition from methadone programs, as well as the increasing incidence of non-narcotic polydrug abuse, led to growing incorporation in, or provision of, educational, vocational and mental health services by abstinence programs. These factors also led to the development of multimodality programs which, despite a drug-free bias, began to offer chemotherapy to selected clients.

Although the movement toward integration of services and integration of professional and paraprofessional staffing patterns is well underway, tensions still appear to exist between professionals and paraprofessionals. These tensions mirror similar antagonisms among traditional mental health providers of service and revolve about the depth of personal involvement appropriate to achieve the rehabilitative end sought. Without rehearsing the full controversy in these pages, the most successful drug programs report that their success is contingent upon the willingness of staff, professional or otherwise, to work long hours

to help clients unravel the many elaborations of their prcblems, and to build, as far as they can, on the groundwork of recovery, without arbitrary limits or unrealistic goals. It is indicated that traditional mental health and education professionals in the drug field have the general reputation of unwillingness to go beyond rather narrow contacts with clients. That is why it is difficult to integrate professionals with paraprofessionals. The exceptions, as always, are dazzling. The internist who not only provides supportive therapy for an addict but also saves his marriage by direct intervention with a seemingly unreasonable wife, and the remedial reading teacher who is not content that her young pupil merely understands what he is reading, but insists that he relate that understanding to the most sophisticated abstract thinking level of which he is capable, serve as models of dedication and ingenuity.

Abstinence programs may offer limited services, consisting of counseling and a specific goal, such as remedial education. In the event that the availability of qualified staffs and funding are limited, there is wisdom in the limitation of the goal, provided that the goal is explicit, so that other programs may refer clients for that particular specialty, and so that the more limited program, aware of its own parameters of assistance, can be ever-conscious of the need to offer clients and their families meaningful referrals and follow-ups to other providers of services.

An outstanding provider of a variety of services in New York City is The Door. Another is the Southeast Nassau Guidance Counseling Center in Wantagh, New York. These programs are different in emphasis, but they illustrate the movement to synthesize comprehensive services to drug addicts and abusers. The Door opens avenues of assistance to persons who may have drug problems, but whose presenting difficulty is often medical or legal: hence the name, The Door, portal to treatment. The SNG Counseling Center is, in operation, a Community Mental Health Center, offering a variety of services to drug abusers, including a highly skilled family therapy component. Services found to be useful in the guidance, treatment and rehabilitation of drug abusers, as well as in preventing the aggravation of preliminary involvement with drugs, include:

- ¶ Individual counseling
- ¶ Group therapy or counseling
- ¶ Marital counseling
- ¶ Family therapy
- ¶ Family planning
- ¶ Day care for children
- ¶ Day care for drug abusers
- ¶ Housing referrals
- ¶ Detoxification; chemotherapy
- ¶ General medical and dental care with referrals to specialists and back-up hospital facilities

¶ On-site vocational training

¶ Vocational training referral

¶ Remedial education

¶ Vocational rehabilitation

¶ Job placement

¶ Legal assistance (criminal, domestic relations, landlord-tenant, etc.)

¶ Provision for transportation to above services not provided on-site

¶ Financial assistance referrals

¶ Recreational activities

¶ Outreach to children "at bay" and to the prisons and courts

The need for the last two services listed has been underscored by several workers in community drug treatment programs. A Commission staff report from Buffalo supports this finding. There are eighteen ambulatory abstinence programs in Buffalo and two methadone programs. One of the programs visited was the West Side Counseling Center, a store-front operation under the auspices of the Division of Addiction Services of the Erie County Department of Mental Health. It offers short-term intervention in the emotional problems of between four hundred fifty and six hundred clients annually. Approximately eighty-five percent of the clients range in ages from fifteen to twenty-five; the rest range in ages from twenty-five to forty-five. Approximately eighty-five percent

of the clients have been involved to some extent with illicit drug use, primarily marihuana and barbiturates. Most present problems, in addition, relating to family conflicts. There has been a reported rise in suicidal ideation among the persons seen. The area serviced is the west side of Buffalo. This is a near-indigent community with a high availability of drugs. Ninety percent of the clients are white, very few are Black. The rest are of Puerto Rican origin and Native Americans.

The single most significant characteristic of the client population was described as an inability to form close personal relations combined with feelings of isolation and inadequacy. The emphasis appears to be supportive: to build upon the strengths of the individual in order to diminish feelings of inadequacy, through counseling and family therapy. The goal is to help the client avoid neurotic and drug-related behavior.

Although the staff of the counseling center could not report that "most clients enter the program carrying a knife or gun", as reported by the Canarsie Youth Center in Brooklyn, New York, they were concerned about increasing gang activity and violence among the young people in that Buffalo neighborhood, as well.

There appeared to be four problems at the Buffalo program. The staff of ten persons, seven of whom have had what appears to be minimal professional training, is able to make excellent contact with young people. However, staff salaries are far below competitive levels, which may retard the most suc-

cessful forms of intervention. Second, vocational training for young people appears to be minimal or non-existent. (The same problem exists in other Buffalo programs). Third, there appear to be no supervised group homes for young people who are in conflict with their families, but who are not truly ready to be considered emancipated.

Fourth, in a heavily populated fifteen-block area, there is only one Boy's Club, which provides neither adequate facilities nor hospitality to engage the young people in the area. It was noted by the Commission staff that a need appeared to exist for teen drop-in centers to be established similar to the centers in Onondaga County. The client population appears to be hostile and rebellious, and yet individuals with problems in the neighborhood are willing to seek counseling, treatment and advice. The lack of recreational facilities geared to such a client population would seem to be a notable omission. Since most clients are on welfare, unemployed or youngsters who live at home and who may not be actively occupied with educational studies, the recreational need and the need for vocational training would seem to be profound.

The availability of vocational training, recreational facilities and drop-in or other types of counseling programs to lure "at risk" youngsters into constructive patterns of adaptation is generally regarded as necessary, but, in addition, the cry of "outreach" is being increasingly heard in the land.

Our 1974 report on prevention presented a highly skeptical view of attempts to deter drug and alcohol abuse through didactic instruction, values clarification and media campaigns. One area in which we felt the presentation of information was vital concerned the existence of available services to children and families "at risk". To mean anything, such information must involve some understanding by the potential client of his own dysfunctional behavior, and the further understanding of which services might prove beneficial in the repair of his dysfunctions. For the troubled youngster with a medical problem, or anxiety he discerns as unusual, or a specific learning problem he, himself, can recognize, the amenability to treatment may follow as a logical consequence, assuming the availability of programs, such as The Door. However, many people do not know how to recognize their own dysfunctions, or if they do, they either cannot or will not relate such dysfunctions to treatment. For those people, outreach is essential to deter resolutions which prey upon dysfunction, particularly drug abuse, gang violence and crime. It is always better to get the individual back into gear at school or at a job, than to try to rescue him after he has attempted to resolve his earlier problems by joining with drug abuse or violence prone contemporaries in antisocial conduct.

To some extent, communication of the nature of dysfunctions and techniques and sources of repair may be general. In order to demonstrate that any individual's fact situation applies

to such generalizations, however, the personal intervention of trained guidance counselors and street workers may be required. Outreach is necessary when the client is not otherwise available. As one witness from Westchester County testified at our hearing in Poughkeepsie, October 2, 1974:

> I spent six years on the streets doing outreach work in Cleveland and in the Bushwick section of Brooklyn where it was essential that whatever treatment took place, took place on street corners, and in families' houses, and sometimes in bars, and subways; and contrary to classical treatment theory, success did not depend upon motivation for treatment... Success really is largely contingent upon my ability to demonstrate the need for help, and in order to demonstrate the need for help, I have to be in the environment where those needing the help are congregating or associating with each other.

Underscoring the need for adequate medical and neurological examinations even regarding patients with a non-narcotic history of drug abuse was the testimony of the Director of the Drug Detoxification, Aftercare and Methadone Maintenance Program at St. Mary's Hospital in Syracuse. Medical evaluation is of primary importance for two reasons, he said. The variety of drugs currently in use in Syracuse requires meticulous differentiation for detoxification and medical treatment. The drugs currently in use are: Heroin, short-acting barbiturates, codeine, morphine, alcohol, cocaine, Librium, Valium, Mellaril, Doriden, LSD, amphetamines, Darvon, Talwin, and an assortment of minor tranquilizers. Differential medical and neurological diagnoses and treatment are also vital with regard to residual brain syndromes associated with prolonged use of non-narcotic drugs, glue and aerosols.

A number of witnesses discussed problems encountered in the treatment of youthful alcohol abusers, which result from separate funding of drug treatment and alcoholism services, possibly preventing reimbursement with drug treatment monies for the care of young alcoholics who seek available counseling from drug treatment programs. This question will be dealt with in detail in our chapter entitled, "The Drug Abuse Control Commission -- A Reappraisal".

RECOMMENDATIONS

We find that the cult of abstinence, which helps a significant number of alcoholics in A.A. to encapsulate their drinking problems, has not been successfully transferred, in most cases, to the problem of heroin addiction and other forms of drug abuse. Because of the A.A. model, the concept of abstinence from drugs as a goal, has been confused with the concept of abstinence from drugs as a therapeutic modality. It is this confusion which has led to the disutility of many therapeutic communities and other drug-free programs.

Since a reasonable treatment alternative must continue to exist for heroin addicts who either do not wish to enter methadone maintenance programs, or who may not be suitable for such programs, and since treatment must be available for non-narcotic drug abusers, we believe that, with the exceptions previously

noted, most drug-free programs would be well-advised to develop along one of the following two lines: (1) Narrow the horizon and offer a very specific service, such as individual counseling or office-work vocational training; or (2) broaden the base to approximate a full, comprehensive mental health facility, including all or most of the medical, social, legal, psychological and vocational support services now available in the better programs. This approach is particularly desirable if drug-free programs plan to continue admitting children and non-drug abusing persons, as they have been doing.*

We make this recommendation mindful that while we know what will not work, until we know what will work, the concretization of purpose of the more limited drug programs, and the concretization of goals of rehabilitating drug abusers in more broadly based programs, would appear to represent sound social policy. In either case, the resocialization and reentry of the client into the general community should serve as the only abstract foundation for treatment. In our chapter on D.A.C.C. we plan to pursue the question of evaluation and how the state can go about determining which drug-free programs "work", in terms of reliable reentry and recidivism statistics. Until such evaluations are performed, however, it will be necessary to confine our recommendations to a refinement of treatment protocols and the continued measurement of compliance.

*Phoenix House reports twenty-nine residents under sixteen years of age (one of whom is eight years old) and fifty-three residents who have never used drugs.

Our specific recommendations for additional D.A.C.C. regulations are as follows:

1. Smaller programs should be required to concretize their services in as explicit a fashion as possible, and, consequently, their admissions criteria, as well.

2. Larger programs, particularly those which admit persons not abusing drugs or persons only minimally involved with drugs, should be required to offer a full range of services, as described herein.

3. All programs should be required to demonstrate the immediate accessibility of medical and psychiatric evaluation and back-up services.

4. Periodic urinalysis and reporting of results of urinalysis to D.A.C.C. should be required of all patients who maintain significant contacts with drug-free programs. Since certain tranquilizers and alcohol may not be detectable in urine samples, programs should be required to demonstrate their capacity to identify individuals abusing such substances.

5. Professional and paraprofessional staff integration should be explicitly detailed, and heightened emphasis placed upon professional capacity to facilitate patient reentry into the general population.

Beyond these recommendations for additions to D.A.C.C. regulations, we further recommend the inclusion of outreach and recreational components in all drug programs.

CHAPTER III

ALCOHOLISM -- EMPHASIS WITHOUT STRESS

A mental health worker recently surveyed the damage attributable to alcohol in the United States each year and sighed, "You know, if alcohol were sought to be introduced to the people of this country today, for the first time, as a drug, the Food and Drug Administration might consider it too toxic to market".*

According to those with responsibilities for treating alcohol-related problems, the overconsumption of alcohol rates as the country's third largest public health problem, after heart disease and cancer. Thirteen thousand people die each year from cirrhosis of the liver; and medical research has uncovered relationships between alcoholism and heart disease, as well as general central nervous system and brain damage. Persons who drink to excess tend to live ten to twelve years less than the non-drinking population.

One half of all of the murders in the United States involve drink, either on the part of the killer, or victim, or both; and one fourth of all of the suicides in the United States

*Analysis of the scope of the alcohol problem provided by the Coordinator of Alcohol Programs of Dutchess County.

are found to have alcohol in their blood streams. There are fifty-eight percent more suicides in the drinking population than in the abstinent population.

One half of each year's fifty-five thousand traffic deaths, and about one half of the million major injuries suffered in automobile accidents can be traced directly to the consumption of alcohol, on the parts of both drivers and pedestrians.

A recent Department of Health, Education, and Welfare study found that alcohol-related problems cost the nation nearly twenty-five billion dollars each year. In New York City, sixty percent of the one million forty-eight thousand young people between the ages of twelve and eighteen use alcohol, and approximately thirty-six thousand of these exhibit problems related to such use.* To demonstrate that while the problem seems most virulent in large cities, other areas of the state also have need for concern, the Commission was informed that Dutchess County has an estimated eleven thousand alcoholics; that in 1973 there were over three thousand accidents, of various types, attributable to alcoholism; twenty-eight drunk driving fatalities; and in 1972, the City of Poughkeepsie, alone, counted five hundred arrests for Driving While Intoxicated and four hundred arrests for public intoxication. Twenty percent of the admissions to the Dutchess County Unit of the Hudson River State Hospital are alcohol related.

*An Addiction Services Agency survey in the fall of 1974 found that of 1,142 pupils interviewed in the ninth to twelfth grades, nearly eighty percent said they had at least one drink recently, and twenty-six percent were regular drinkers.

WHAT IS ALCOHOLISM?

In attempting to create a climate of enlightened public opinion, mental health workers have for years been plagued by the colloquial usage of terms describing gross behavioral or emotional disturbances as epithets. At times, the words are so blinding to the intellect that they must be removed entirely from the lexicon, as New York State removed the word insanity from its Mental Hygiene Law, to promote more humane treatment of the mentally ill. The problem is further compounded in the Platonic sense by the fact that because a term has come into existence, there will be those who insist that there must be a valid idea which that term represents. Prior to the identification of the germ theory of disease, scientists were persuaded, no less than the general public, that the cause of disease was "bad air". The existence of the concept of bad air was, in and of itself, an intellectual obstacle to the refinement of the theory of communicable disease.

Alcoholism, like "bad air" is an imprecise and unscientific term. Like insanity, it is also a term heavily prejudiced by usage as an epithet. In a memorable aside, the late Joe E. Lewis once responded to a demand that he explain the difference between an "alcoholic" and a "drunk". Said Lewis, "They're the same; only a drunk doesn't have to go to all those...meetings".

In recent years, scientists have moved away from attempting a definition of alcoholism and toward descriptions of the role that alcohol plays in the chemistry, the biology and

the behavior of the human organism. At the same time, extremely well-motivated and often articulate and well-informed humanitarians have been attempting to persuade the public that there is indeed such a thing as alcoholism, and that it is a "disease". Those who have been through the experience of dealing with unrefined definitions and diagnoses of mental illness, as a "disease", recognize that the categorization of a group of human disorders as a "disease" does not necessarily accrue to the benefit of the people afflicted. As in the case of drug addiction, the response to the term "illness" is often the creation of social policies requiring "quarantine" and "cure", which may be both self-defeating and futile.

There are three classic theories of alcoholism. One is that the existence of neurotic or personality disorders, such as an obsessive-compulsive neurosis, leads to the uncontrollable use of alcohol. The addiction theory is that heavy drinking, over a period of time, leads to cumulative tolerances, behavioral disturbances, and organic damage. A third viewpoint is that any drinker who has an as yet undifferentiated biological or biochemical imbalance will turn into an uncontrollable drinker. Less sophisticated theories tend to suggest that the products of heavy drinking are a combination of organic and social retribution for, at least initially, controllable self-indulgence.

What we know, in the simplest terms, is that because alcohol has a sedative effect, and because it tends to release inhibitions, it is a very attractive substance to many. Because

it is a socially accepted mood-altering drug, its use is widespread. Alcohol use may produce consequences of unwanted human behavior. Such behavior can occur as a transient, situational difficulty, or it can occur on a continuing bases, resulting in social, familial or occupational dysfunctions. Prolonged excessive alcohol use invariably leads to organic deterioration, principally in the two vital organs which do not have regenerative powers, the liver and the brain.

The proper role of government, we believe, is not to further incapacitate afflicted individuals with opprobrious and controversial terminology or categorizations. The proper role of government is threefold:

1. To attempt to help individuals reduce their own alcohol-related behavior, which results in significant interruptions of the peace and order of society, such as drunk driving and assaults.

2. To help individuals find adequate care for the health problems associated with heavy drinking.

3. To help researchers in their attempts to understand why some people drink to the point of causing problems one and two, and what proper means may be used to forestall or diminish these consequences.

We believe that as long as there is serious controversy, it is counterproductive to assert a single concept or definition of alcoholism and thereby shift the emphasis of government towards a process, one step removed from namecalling, of trying to identify

just who is and who is not an alcoholic. We believe that government should concentrate on dealing with the dysfunctions associated with alcohol use, in terms of remedying those dysfunctions, even as it encourages researchers to further refine their study of the relationship among alcohol, physiology, psychology and behavior.

TREATMENT OPPORTUNITIES

With the removal of public intoxication from the Penal Law, the Department of Mental Hygiene has announced the intention to establish "sobering-up stations" to which individuals currently intoxicated by alcohol can either bring themselves or be brought by the police on a voluntary basis. The National Council on Alcoholism refers to such stations as "sleep-off centers", which is a less judgmental as well as a more hospitable term. The model of the sobering-up station to be replicated throughout the State is the one located at the Rescue Mission in Syracuse, New York. It has a capacity of fourteen beds and is operated on the basis of a contract between the Department of Mental Hygiene and the Onondaga County Department of Mental Health. It is staffed by paramedics and part-time medical students attending the Upstate Medical Center. No drugs are administered at this unit.

Clients who seek admission to the sobering-up station are self-referrals, may be brought in by the police or are picked up by the alcohol outreach workers operating a patrol van. The admission procedure is voluntary. Instead of being arrested and

jailed, the people are brought to the sobering-up station, put to bed and carefully observed. An individual too ill to be handled in the sobering-up station is referred to the emergency room of a hospital and then can be admitted from that point to the detoxification service if he requires this highly skilled medical service.

Special outreach services exist in Rochester, Syracuse, and New York City (Manhattan Bowery Project). Other communities make use of a variety of methods in bringing the alcoholic to an appropriate service. This requires an organized information service to police agencies and orientation as to how best to utilize sobering-up stations and how to elicit cooperation from debilitated men, as opposed to previous arresting methods. Proper approach by the police is necessary because sobering-up stations must be a totally voluntary service; otherwise, referral on to other levels of treatment will be met with resistance by the debilitated person.

Communities may wish to encourage such voluntary agencies as missions and the Salvation Army, where large numbers of alcoholic persons congregate and receive care, to modify their programs to include outreach and sobering-up services. The new services could be carried out in conjunction with the traditional services provided by these agencies.

Special problems exist in rural and small urban centers. It is questionable whether a sobering-up station as described above would be feasible in such areas. However, some medical screening is essential to ascertain the medical condition of the individual and whether or not further medical treatment (detoxification or

withdrawal) is required. Special arrangements will have to be made with various hospitals in rural areas to provide the needed services that could be shared by a number of localities. Implementation of such programs on a regional basis is looked upon as the solution to the delivery problem in less populated areas.

The basic caution to the Department, expressed by treatment experts, has been that many persons who are public intoxicants may have serious alcohol and non-alcohol related medical problems. Indeed, the initial question would be whether a person who appears intoxicated may actually be ill, in quite another sense. While a close working liaison is supposed to exist between a sobering-up station, which may have only a nurse, a few recovered alcoholics and a social worker on hand, and a general hospital, a detoxification unit, or other well-equipped medical facility, the viability of such liaison could, if not carefully enforced, turn out to be more speculative than real. We join others in cautioning that sobering-up stations not be used as substitute providers of non-health care, but rather be used to secure health care for those inebriates who may need usch attention but have difficulty obtaining it.

Detoxification services threat the acute medical problems of alcoholism. They are well staffed with medical and nursing personnel and are not the appropriate service for most of the people who are simply intoxicated. The detoxification service is

usually located in or is closely associated with a general hospital in order that third-party medical payments can be obtained to defray the cost of the program.* These detoxification units serve the total population in the community, not just the person arrested for public intoxication. The Bowery detoxification service is located in the men's shelter and has backup services of St. Vincent's Hospital. The detoxification unit in Syracuse is part of the Crouse-Irving Memorial Hospital. The Albany detoxification unit is at St. Peter's Hospital.

Again, major metropolitan areas need this specialized concentrated service. There are existing separate detoxification units in Albany, Buffalo, Rochester, Syracuse and New York City. None has less than 14 beds and all operate seven days a week around the clock.

In Rochester, the 15 bed detoxification unit is not located in a general hospital and is staffed primarily by nurses with doctors visiting for two hours a day. This cuts costs of per day care to approximately $50, which is roughly one-half the cost of general hospital beds in this community. The Rochester unit is located one-half mile from a general hospital that serves as a backup for seriously medically ill individuals or those whose withdrawal becomes complicated by d.t.'s, severe seizures or non-response to medication. This backup has only been utilized a dozen times in a year's operation. In rural areas, agreements will have to be worked out on an individual basis with general hospitals to provide this service. The services will likely be modest in

*Department of Mental Hygiene Planning Guidelines, 1973-74.

size with the number of beds depending upon population to be served.

Since the debilitated individuals are generally homeless, jobless and without resources and family and in poor health, they must be referred where these basic needs can be provided following detoxification. We have found that there are major metropolitan areas that presently have such existing resources. These services differ from community to community in size and range of services. Also, some communities need to coordinate existing services for better utilization.

Basically, a residential rehabilitation program needs to have patients in residence on a voluntary basis from one to two months as in the Monroe County Continued Care Program. Providers of this service have experienced general willingness on the part of the debilitated man to stay engaged for this period of time on a voluntary basis. Monroe County uses antabuse as a mandatory drug for patients in the rehabilitation program.*

The state hospital alcoholism rehabilitation units are another example of this type of program in which the goal is to quickly restore physical health and initiate change in life style of the individual by maximizing his ego strengths and helping him to re-enter society as a productive member. These agencies need to be an advocate for the debilitated individual in utilizing after-care services. (To the eight existing facilities, eleven more will be added as a result of legislation enacted in 1974.)

*Compare comments, infra, of Dr. Abrahams, who opposes this technique.

The halfway house is a transitional facility which can be used by the alcoholic following his return to the community from an inpatient treatment resource. During his residence at the halfway house, the alcoholic is provided with meals and lodging, is helped to make use of community resources for alcoholism treatment, employment and vocational needs. The halfway house, being a buffer between inpatient treatment and independent living in the community, is a major resource in assisting the alcoholic towards fully independent living. Without the services of the halfway house, many alcoholics experience great difficulty in successfully utilizing the benefits achieved during an inpatient stay and would be more likely to fail if suddenly placed in the community without the assistance of this type of program.

While in the halfway house, efforts should be made to assist the alcoholic to obtain the services of the many social agencies which are geared to serve him, such as employment services, vocational services and financial assistance from the county department of social services.

The Department of Mental Hygiene has suggested the utilization of congregate living facilities or hostels for the alcoholic who, because of his debilitation, would not be expected to achieve fully independent functioning. Financial assistance from the local county social service department could, reportedly, be utilized in both the hostel and halfway house programs so as to help defray operational costs.

The aftercare needs for patients center around their re-entry into the community and include the need for certain services provided by Social Services, Office of Vocational Rehabilitation and the New York State Employment Service. The Aftercare needs provided by these agencies could assist the individual in his first attempts at living independently after a treatment or rehabilitation experience. Funds for living expenses, medical and alcoholism services can be provided through the local county social services department. The Office of Vocational Rehabilitation and the New York State Employment Service should assist the alcoholic in seeking employment and upgrading his work skills.

These services are components of a comprehensive service which may have to be phased in, as it may not be possible for a given community to provide all at once. In order to help insure that these services are available, they should be incorporated as part of any proposal for the alcoholic. This will not only insure coordination of services but may well be the only means by which funds could be obtained to make the services of specialized vocational and employment counseling available.

A CASE STUDY

A case study of a treatment center, its problems and its progress has been provided by the Commission staff:

Members of the Commission staff visited the Bedford-Stuyvesant Treatment Center on October 7, 1974. The visit included a brief tour of the premises and a long question and answer

session with the clinical director, Dr. Andrew W. Abrahams, who is an internist. The visit lasted two and a half hours.

The Bedford Stuyvesant Treatment Center was established two years ago in a rather aging community-center type building. On November 1, 1974 a complete renovation of the premises was scheduled to begin, utilizing a grant of $335,000 from the Model Cities Program. The Center began with an 8-year decreasing fund grant from NIAAA of $551,000, decreasing 10% each year. The grant is matched by a Health and Hospital Corp. grant which increases each year as the federal grant decreases. There is an increasing grant from the State Division of Alcoholism of $85,000 and a steady grant of $140,000 from the New York City Department of Mental Health and Mental Retardation services. This comprises an annual total budget of $1.4 million.

The initial administrative problems of the program were that its design was functionally related to Downstate Medical Center and only nominally redrafted at the request of the Federal government for a free-standing treatment program. According to Dr. Abrahams, they are much closer now to the goal of a free-standing treatment program, both in actuality as well as in design, than they were two years ago. The federal grant mandates certain basic services:

1. Outpatient care, including medical, psychological and social work
2. Twenty-four hour emergency care

3. A 12-bed detoxification unit
4. A 22-bed-long stay ward
5. A 50-unit residential halfway house
6. Community education and evaluation

Apparently the services now offered pending renovation are out-patient care; 9:00 a.m. to 12:00 a.m. emergency service; community education and some consultation.

The area served is the extremely depressed Brooklyn ghetto neighborhood known as Bedford-Stuyvesant. The Center serves Blacks, whites and Puerto Ricans, with a majority of Blacks. The ages treated are from 18 up, with the majority in their 40's.

Although the model of the treatment program is a free-standing clinic, certain liaison continues to exist with Kings County Hospital for the hiring of personnel, for billing purposes, and for purchase orders. Other administrative decisions regarding matters beyond the day-to-day operation of the Center are made with the Health and Hospital Corp.

There are 1200 patients who are registered, 400 of whom are considered active in that they avail themselves of at least one service (counseling) once within any three-month period. When a patient is in need of hospitalization, referrals are made to Swedish Hospital, Long Island College Hospital and Kings County Hospital. Dr. Abrahams says that many of his clients who are alcoholics often do not get adequate care or attention

paid to their physical and emotional problems through existing health services. They are discriminated against because they are alcoholics as well as because they are poor and often black. Dr. Abrahams says that there is another alcoholism program in Brooklyn which does nothing but treat secondary problems of alcoholism, such as physical distress.

The Bedford-Stuyvesant Treatment Center emphasizes an attack upon th alleged psychogenic causes of alcoholism - either in terms of emotional disturbances or internalized sociological factors which may give rise to low tolerance of frustration. Group counseling is the usual mode of treatment. Other aspects of treatment include a full medical clinic, individual counseling, health education, some vocational guidance (although there is no trained vocational rehabilitation counselor on the staff and Dr. Abrahams not only sees the need for such a staff member, but also would like to have a job developer as well), and recreational therapy (including a well-used day room). Dr. Abrahams himself engages in lectures in the community. Alcoholics Anonymous has representatives assigned to the program. Other techniques used involve the acting out of problems by patients with audio visual playback to allow them to observe their own methods for dealing with problems.

The staff is made up of counselors who have been trained at the Center, including several recovered alcoholics, clerks, a psychiatrist and a psychiatric social worker. A total of eight of the employees on the staff are alcoholics who were success-

fully rehabilitated at the program.

Dr. Abrahams would like to be able to attract more doctors into the program. He feels that a maximum salary of $23,000 per year is simply insufficient. Additional funding would permit him to pay more. He would use the extra medical personnel to expand his treatment program to include polydrug abuse related to the abuse of alcohol. At the present time he rejects all applicants who use drugs other than alcohol. He believes the polydrug-alcohol abuse problem is extremely serious, particular among young people. He does not see a dramatic increase in teen-age alcoholism, but he welcomes the emphasis and attention on what has always been a severe problem -- that of teen-age drinking in the Bedford-Stuyvesant area. He is also very much opposed to the use of antabuse, and to suggestions that its use be made mandatory, either as a condition of treatment or the return of a driver's license. He believes that antabuse does not make most of his patients any sicker than they already get from the amounts of alcohol that they ingest. If they drink on top of using antabuse, they may die. The antabuse can be used by severely depressed people in suicide attempts, and Dr. Abrahams takes the view that abstinence from any and all chemical substances can be the only solution for the problem of alcohol and drug addiction.

Parenthetically, Dr. Abrahams called our attention to his experience with persons maintained on methadone who drink wine to obtain a high. He states that these people tend to de-

velop a tolerance to the alcohol much more rapidly than the ordinary alcoholic and therefore run a greater risk of early deterioration and death.

In order to expand and treat more people, particularly the cross-addicted individual, more money will be needed. Dr. Abrahams also would like more money to establish a full job development program, including a sheltered workshop. He was apparently unaware of efforts by other treatment agencies to develop jobs. However, he stated that the problem of employment for reformed alcoholics is a particularly difficult one. Often the reformed alcoholic is an older person who has not worked in many years. There may be minor organic impairments, residual from prolonged alcoholism. Such individuals may not function in terms of their potential prior to alcoholism, but they may be competent to function at another level. Employers, however, seldom see it that way and Dr. Abrahams is not satisfied with efforts of the State Division of Labor in assisting poor rehabilitated alcoholics.

However, the picture is not entirely bleak. Only 41% of the patients in treatment are Medicaid eligible, which means that approximately 59% are working.

Evaluation has not yet begun of this treatment program. Dr. Abrahams would guess that those who have been rehabilitated during the two-year maximum period of the program would constitute approximately 40% of the total enrollment thus far. He

further estimates that of those who relapse while in treatment, approximately 23% are retrieved. Since he has no hard statistics, it may be that these figures are optimistic.

General discussion of alcoholism led to some interesting views of Dr. Abrahams. He believes there is no such thing as a problem drinker. He believes that any person who drinks with regard to avoiding or coping with any difficult situation is an alcoholic and should stop drinking entirely, forever. He states that the amount of alcohol consumed is not significant with regard to alcoholism. (There is, of course, another view... that heavy habitual drinking can lead to chemical addiction. Dr. Abrahams does not share this view.) Dr. Abrahams states that what is important in determining whether or not an individual is an alcoholic is what any one drink means to the individual. He believes that all alcoholism is based upon an inability to cope with frustration or sociological or psychological problems. Any use of alcohol in such context must terminate entirely, particularly because there is a cumulative chemical tolerance which never diminishes. Therefore, any return of emotional problems could begin a new serious drinking habit.

The Commission staff looked over the facility and was extremely impressed by the fact that the atmosphere appears to be non-threatening and congenial, and people appeared to be in the process of being helped. This is particularly impressive in light of the rather awkward atmosphere of several drug treatment

programs visited and in light of the fact that the Bedford-Stuyvesant Treatment Center is heavily policed by both male and female unarmed hospital police force members. Quarters are cramped and a large amount of space appears to be set aside for record keeping. A small ward has been set up for people who come to the Center in an intoxicated condition. They are permitted to sleep off their intoxication without recriminations or repercussions.

Returning to a discussion with Dr. Abrahams, he appeared quite skeptical about the medical sufficiency of the so-called sobering-up stations to be set up by the State Department of Mental Hygiene, Division of Alcoholism. (On the other hand, the Department bases its plans on the significant experience which has already been accumulated with properly run, adequately supported sobering-up stations in this state and elsewhere.)

With regard to changes in the laws or regulations, he had the following suggestions:

1. He believes that the federal government should reevaluate its policy of giving dishonorable discharges for alcoholism, which negates the basic premise that alcoholism is an illness and which follows the man as an impediment to employment.

2. In the event that funding is expanded for poly-drug and alcohol abuse, he would prefer that the money go through existing alcoholism funding conduits and not through the Drug Abuse Control Commission.

3. In the event that funding is made more plentiful, he believes that a proliferation of programs should be avoided, but that good programs should be better financed.

4. While he would like to see all health and mental health services available concurrently in proximity to one another, he believes that the role of alcohol treatment requires emphasis and should not be under-emphasized in an attempt to unify services.

5. He favors the use of crisis situations, objective or subjective on the part of the alcoholic, to induce him into the treatment process.

RESEARCH AND EDUCATION

In 1967, then Governor Nelson A. Rockefeller announced the selection of Buffalo as the site of a projected Research Institute on Alcoholism. That city was chosen to take advantage of the new campus for the State University of New York at Buffalo, and also to relate to a community known for its diversity of population and problems, but of manageable size for purposes of social research projects.

The Research Institute began its operation in July of 1973 in an old federal building donated by the Department of Health, Education, and Welfare to the State Department of Mental Hygiene. Its annual budget is just under one million dollars, although an original recommendation for six million dollars was reportedly sent to

the Governor by his committee of research authorities designated at the suggestion of the Advisory Council on Alcoholism.

The Director of the Research Institute reports that approximately half of the projects being undertaken are in the biological field and the other half are sociological. Apparently, all of the research can be categorized as "applied", in the sense that practical applications of expected research findings are foreseeable. On the other hand, some of the projects are in the nature of long-term series of experiments and collections of data, with no immediate utilitarian expectations. One short-term project is the statistical analysis of the public inebriate population in Buffalo, and one long-term research project looks into the mechanisms of intoxication and alcohol addiction. Additionally, the Research Institute plans to supervise an evaluative component in the sobering-up stations established by the Department of Mental Hygiene Division of Alcoholism, with respect to the decriminalization of public inebriation, effective January 1, 1975. It should be noted that the Institute, although a part of the Department of Mental Hygiene, is not under the Division of Alcoholism.

The Institute staff is comprised of 16 professionals familiar with disciplines such as psychology, epidemiology and behavioral studies.

Other studies being made by the Institute relate to outcomes of arrests for driving while intoxicated, and evaluations of evaluations of driving while intoxicated programs.

The Commission staff discussed with the Institute's staff the question of a dichotomy between funding for research and funding for treatment. Because the funding comes from different sources or is rigidly categorized, evaluative components in treatment programs both for drugs and alcohol tend to be either non-existent or short-changed. For example, the National Institute of Mental Health divides treatment and research funding. The Federal government tends to be more likely to divide funds along these lines.

Research projects contemplated by the Institute appear to fall into five categories:

1. Epidemiology of alcohol-related problems.
2. Outcomes of treatment or arrest.
3. The effects of alcohol on the human organism, alone or in conjunction with other drugs.
4. Evaluations of specific governmental programs relating to alcohol.
5. The development of preventive educational programs.

With all due respect to the expertise available at the Institute and the need to allow researchers to follow, to some extent, their own inclinations in order to hold their interest, there does appear to be something of a scatter-shot approach* to research at the Institute, without any specific ordering of pri-

*New York State Task Force on Alcohol Problems, Committee on Research, Position Paper, September, 1974, p.4.

orities. The issue seems to be how to maintain the independence of a research organization while suggesting that it clearly define tasks more responsive to the immediate needs of the State. Since this Commission is also an independent evaluative agency, we make the following research recommendations:

RECOMMENDATIONS

1. At the present time the State spends approximately six million dollars each year on various modalities of treatment for persons who have alcohol-related problems. The State also appropriates over one hundred million dollars a year for drug treatment programs, for an actual and a potential client population perhaps one third as large as the State's problem drinking population. As the focus shifts to providing more services to persons with alcohol and polydrug-alcohol problems, it would be sound social policy to begin a study of each of the present treatment modalities, with an evaluation of success with patients within each type of program, as well as a comparison of the success of different types of programs. In that way, repetitions of the mistakes made in the hurried establishment and funding of drug programs may be avoided.

2. Continued pressure should be brought to bear upon funding sources to combine research with treatment, for the purpose of establishing pilot treatment programs on a purely research basis, so that results may be evaluated concurrently with the delivery of treatment services. Viewed in this perspective, new

forms of treatment would become aspects of research.

3. Epidemiological studies are useful in determining the scope of the problem. Cooperation between the State Health Department and the Institute might serve to stretch precious resources while accomplishing this purpose.

4. When speaking of the subjects of alcohol and education, many people refer to the idea that educational efforts regarding "values clarification", "decisionmaking", and warnings against alcohol abuse may deter such abuse. Efforts in the past that have failed often prompt the search for a new jargon and catchier slogans, and declarations that future efforts will avoid previous mistakes. A full analysis of these ideas appears in our report on Drug Abuse Prevention (cited above). Aside from informing people about the nature of human dysfunctions and calling their attention on an individual basis to their own problems in this regard coupled with giving them opportunities to receive help, there is little that education can achieve in the sense of deterring substance abuse through verbal manipulative techniques.

However, education in the sense of teaching professionals how to deal with problems of alcohol abuse among their patients and their clients has been a much neglected area of concern. According to the Department of Mental Hygiene, there are seven subdivisions of students whose ultimate clients and patients would benefit from educational efforts at this level. These subdivisions of students are those involved in professional degree education, such as medicine, psychology, nursing, social work and law; those

involved in post professional degree education; undergraduates seeking degrees in health care or human services; candidates for inservice education within existing agencies; participants in continuing education for professionals; those likely to attend periodic workshops including law enforcement officials and the judiciary; and alcoholism counselors.

We recommend that the Alcoholism Research Institute prepare courses of study for these categories of students, particularly family physicians, whose lack of familiarity with alcohol-related problems has been well documented.*

5. The excellent work of Alcoholics Anonymous is well known. For some of the persons who cannot respond to traditional psychiatric intervention and casework, A.A. represents not only a last hope, but a real hope. According to A.A. nearly half of the people who remain members never drink again. Virtually every worthwhile treatment program today offers easy access to A.A. We believe that a prime research effort should be made to understand conceptually how A.A. achieves its results, and to what extent the concept might be broadened, without inviting the previously described errors of the therapeutic communities.

Other studies of the Institute should, of course, proceed. And in order to meet the suggested order of priorities, additional funding may be needed. Our recommendation in this regard is that moneys saved in the drug abuse field should be reallocated to alcohol research. Beyond those savings, however, ad-

*Planning Guidelines, New York State Department of Mental Hygiene, 1973-1974, pp. 69-73.

ditional funds may ultimately be needed for further alcohol-related research and treatment. In recommending that such increases be preceded by meaningful evaluations, we are also mindful of the fact that revenues from the sale of alcoholic beverages in New York State exceed three hundred fifty million dollars, annually.* The gross cost to the State of alcohol-related problems is approximately one billion dollars. Yet the State spends only seven million dollars for treatment and research. We do not urge spending for its own sake. However, we also do not oppose justifiable expenditures for evaluations and for programs that work.

Finally, on the subject of treatment, itself, we make the following recommendation:

Alcohol-related problems occur with varying degrees of severity and at differing points in time among a variety of individuals. It is necessary that treatment services be provided in a comprehensive and systematic way, with built-in mechanisms to assure accessibility to the services, continuity of care, and availability of treatment for as long as individuals require it. Programs should not be developed which are piecemeal in character, possibly leading to "revolving door" utilization without significant impact on the individuals involved.

*The New York Times, Nov. 30, 1974.

LETTER TO CHAIRMAN

FROM

STATE DEPARTMENT OF

MENTAL HYGIENE

DIVISION OF ALCOHOLISM

Form 39 D M H

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JOHN R. BUTLER
ASSOCIATE COMMISSIONER

December 10, 1974

The Honorable Emeel S. Betros
Chairman
Temporary State Commission to
Evaluate the Drug Laws
270 Broadway
Room 1800
New York, New York 10007

Dear Assemblyman Betros:

In reply to your recent letter requesting additional information on the state alcoholism program, I believe the following will be of assistance to you.

Alcoholism treatment programs funded by this Department fall into two broad categories:

Alcoholism rehabilitation units at the state psychiatric centers which are funded and operated directly by the Department of Mental Hygiene.

Alcoholism treatment services which are funded by the Department of Mental Hygiene by either 100% contracts for a 3-year period or by state aid. The contracts are with the county mental health, mental retardation, and alcoholism services boards which sub-contract for the service or operate the service directly.

Enclosed is a listing of the psychiatric centers with alcoholism rehabilitation units. These are the treatment services funded and operated directly by the Department of Mental Hygiene. Legislation earlier this year gave the Department the authority and funds to organize 11 new units which are now in the process of being opened.

Concerning alcoholism treatment services which are funded either by 100% contracts with the Division of Alcoholism or by state aid from the Department of Mental Hygiene, the Division of Alcoholism since 1962 has used a significant amount of its funds to begin new treatment services for 100% contracts for a 3-year period.

After the 3-year period the treatment service, provided it has become a valuable community resource, is funded by state aid (50% of the budget coming from the locality and the remainder from the Department of Mental Hygiene). This funding mechanism has proven to be valuable in developing alcoholism programs throughout the state.

In listing the treatment services which have been funded by the Department of Mental Hygiene, I have grouped them by the areas served by the Department's Regional Offices. A number of programs such as councils on alcoholism, coordinators of alcoholism services of county mental health, mental retardation and alcoholism services boards, occupational alcoholism programs, training, and public education programs have also been developed throughout the state, but they are not listed here.

NEW YORK CITY REGIONAL OFFICE

Beth Israel Medical Center

Bellevue Hospital

Columbus - ACCEPT Hospital

Harlem Hospital

Hospital for Joint Diseases

Bronx-Municipal Hospital Center

Bedford-Stuyvesant Alcoholism Program

Cumberland Hospital

Kings County Hospital and Sunset Park Clinic

Manhattan Bowery Project

St. Luke's Hospital Center

Bronx-Lebanon Hospital Center

Long Island College Hospital

City Hospital Center at Elmhurst

Queens General

Enclosed is a directory of resources in New York City and in it you will find detailed information on the above programs.

LONG ISLAND REGIONAL OFFICE

Nassau County Medical Center (Meadowbrook Hospital)
2201 Hempstead Avenue
East Meadow, New York 11554

Nassau County Medical Center (Halfway House)
Old Country Road
Farmingdale, New York 11735

Nassau County Satellite Clinics (Serving Roosevelt Catchment area)
Mental Health Clinic
Roosevelt, L.I., New York 11575

MID-HUDSON REGIONAL OFFICE

The Alcoholism Treatment Program
Rockland County Mental Health Center
Summit Park Road
Pomona, New York 10970

Outpatient Alcoholism Clinic - Dutchess County
280 North Road
Poughkeepsie, New York 12601

Outpatient Alcoholism Clinic - Westchester County (Yonkers)
45 Warbuton Avenue
Yonkers, New York 10701

Halfway House for Men - Westchester County
14 Longview Avenue
White Plains, New York 10605

Halfway House for Women - Westchester County
Serenity House
153 Longview Avenue
White Plains, New York 10605

Rehabilitation Program at Journeymen - Westchester County
51 W. 8th Street
Mt. Vernon, New York 10550

ALBANY REGIONAL OFFICE

Alcoholism Treatment Program
St. Peter's Hospital
315 S. Manning Boulevard
Albany, New York 12208

Halfway House - Albany County
Hospitality House
6 Madison Place
Albany, New York

Outpatient Clinic - Schenectady County
The Alcoholism Council of Schenectady County
277 State Street
Schenectady, New York

Alcoholism Center of Rensselaer County
5 Broadway
Troy, New York 12180

Outpatient Clinic - Oneida County
Department of Mental Health
1124 Mohawk Street
Utica, New York 13501

SYRACUSE REGIONAL OFFICE

Alcoholism Treatment Program
A. C. Silverman Hospital
345 Renwick Avenue
Syracuse, New York 13210

Halfway House for Men
Brick House, Inc.
121 Green Street
Syracuse, New York 13203

Halfway House for Women
Brick House for Women
123 Green Street
Syracuse, New York 13203

Sobering- Up Station
Rescue Mission Alliance
811 East Washington Street
Syracuse, New York 13210

Alcoholism Treatment Program - Broome County
Binghamton General Hospital
Binghamton, New York

Halfway House and Hostel - Broome County
Fairview Halfway House
110 Fairview Avenue
Binghamton, New York 13904

NORTH COUNTRY REGIONAL OFFICE

Alcoholism Treatment Program Centered At:

Jefferson County Committee on Alcoholism
104 Paddock Avenue
Watertown, New York 13601

Mercy Hospital
218 Stone Street
Watertown, New York 13601

ROCHESTER REGIONAL OFFICE

Alcoholism Program
Rochester Mental Health Center
1299 Portland Avenue
Rochester, New York 14607

Halfway House for Men
353 University Avenue
Rochester, New York 14607

Hostel for Men
Crossroads House
269 Alexander Street
Rochester, New York 14607

Halfway House for Men
440 Plymouth Avenue, South
Rochester, New York 14608

Alcoholism Treatment Program
St. Joseph's Hospital
Elmira, New York 14901

BUFFALO REGIONAL OFFICE

Alcoholism Treatment Program
E. J. Meyer Memorial Hospital
Buffalo, New York

Alcoholism Treatment Program for Women
Mental Health Center
Buffalo General Hospital
80 Goodrich Street
Buffalo, New York 14203

Buffalo Inner-City Alcoholism Program
Drop-In Center
132 N. Hampton Street
Buffalo, New York

1:2

During the fiscal year in 1973-74, there were 4,265 admissions to the alcoholism rehabilitation units at the state psychiatric centers accounting for 13% of all admissions to the psychiatric centers. The average patient stay in the alcoholism rehabilitation unit was 35 days. It is expected that with the increased capacity for alcoholism rehabilitation programs at the psychiatric centers (from 510 beds to 870 beds with the new legislation mentioned above), there will be approximately 7,200 admissions a year. During the fiscal year 1973-74 there were 38,886 admissions to alcoholism treatment facilities at the local level, and some 251,247 total visits to these units during the year.

It is estimated that there are 900,000 persons with serious alcoholism problems in New York State. The treatment resource in both the public and the private sectors must be greatly expanded to meet the needs of this major public health problem. Progress must be made in the immediate future in establishing sobering-up stations throughout the state. As you know, public intoxication is to be eliminated from the State Penal Code as of January, 1976. In addition to the need for sobering-up stations for that part of the population now arrested and jailed for public intoxication, it is expected that the program on public intoxication will create demands for additional alcoholism treatment and rehabilitation services--with the sobering-up stations serving as an entree into a treatment program. Other programs which can also be expected to increase the demand for treatment programs are the occupational alcoholism programs developing in industrial and governmental organizations as well as programs in the area of alcohol and highway safety.

The funds available to the Division of Alcoholism are outlined below:

$ 6.	million in state purposes funds
2.4	million additional state purposes funds from the legislation authorizing the new rehabilitation units at state psychiatric centers (Phase-in funds, full annual amount approximately $5 million)
3.4	million federal formula grant
2.1	million federally impounded funds (available for this year only)
.7	million in federal project grants award to the division
$ 14.6	million

The Division of Alcoholism has been working closely with a state planning task force to develop a comprehensive plan on alcohol abuse and alcoholism. I believe the major recommendations of this committee will be available in January and that the total report will probably be available in February of 1975. This report should provide you with a great deal more information on directions and aid programs which should be pursued by the Division of Alcoholism over the next several years. While the Executive Committee of the State Planning Task Force has not yet acted upon the major recommendations, the Division's staff has proposed that the total budget for the state alcoholism program over the next five years should be at a level of approximately $50 million (both state and federal funds) by the end of the five year period.

While this information is quite general, perhaps it gives you some answers to the questions you raised in your letter. We will, of course, be pleased to give you more detailed information or to meet with you to expand on any of the subjects outlined above.

Yours truly,

John R. Butler

John R. Butler
Associate Commissioner

JRB:jv
Enclosures

CHAPTER IV

CHILDREN AND PARENTS: TIME FOR RECONCILIATION

What We Have Learned in Five Years

On December 14, 1969, Walter Vandermeer was found dead of an overdose of heroin in a tenement hall bathroom. He was under five feet tall and he was 12 years old. His death received a good deal of journalistic attention, notably the lengthy write-up, "Obituary of a Heroin Addict", The New York Times, January 12, 1970, appended to this chapter. In the ensuing five years, many lessons have been learned about how to help children overcome a drug habit. A few lessons have been learned about how to help children who are expressing their trouble in other ways. Some lessons have been applied, to a limited extent. Others have served to modify our thinking, but not yet our priorities and our programs.

This Commission, in evaluating the effectiveness of programs whose purpose is to prevent or to treat drug abuse, finds Walter's story instructive.

Was Walter a child who had unfortunately never come to the attention of public officials? Was he one of those never "identified" officially as in need of help? By no means. Walter was known to the Family Court, the Society for the Prevention of Cruelty to Children, the Department of Social Services (both to

its Bureau of Child Welfare and as part of a family unit receiving Aid to Dependent Children support), the Board of Education's Bureau of Attendance and Bureau for the Education of Socially Maladjusted Children, the Wiltwyck School for Boys, and the Office of Probation. He had been in the Queens Shelter of the Society for the Prevention of Cruelty to Children, the Children's Center run by the Department of Social Services for neglected children; Patterson House, the halfway house for children who had been living at Wiltwyck; Wiltwyck's upstate campus.

Along the way, had no one cared? Not so at all. Walter's mother cared, even to the point of pleading with the court to have him returned to her rather than sent to a state training school school. His older sister cared. She encouraged her mother's plea, because of her own destructive experience in a training school. His godmother cared enough to invite him to live with her if her son were to be inducted into the army. His counselor at Wiltwyck cared, and Walter continued to visit him, even after both had left Wiltwyck, until that young man left New York to live elsewhere. His next oldest brother, Tony, cared a great deal. Tony had been placed, through the special interest of a probation officer, in a home in Yonkers operated by a private agency, and had made what was regarded as a highly successful adjustment there. Tony tried to interest the agency caring for him in the plight of his brother, but failed. The two boys, despite Tony's concern for and attachment to Walter, were never placed together.

Was Walter deprived of recommended care because of insufficient funding? Did he die, because not enough was spent on his salvation?

On the contrary. From March, 1967, when he was nine, until October 1968, Walter was in placement, (shifted to five different places in fifteen months). He finally arrived at Wiltwyck in June, 1968 but Wiltwyck returned him to Family Court because he kept running away. Those twenty-one months of placement cost at least twenty thousand dollars. In addition, of course, was the cost of the Family Court proceedings and of the time spent on him by the Office of Probation and by the Board of Education.

With all this official attention, all these people who cared, and all this money spent, why, then, was Walter so sad, so uncared for, and, finally, why did he die in a tenement hallway toilet?

Had he given up on himself? No, apparently not. The New York Times article mentions that Walter, upon being given a a new pair of shoes by a neighbor, said he would save them for when he went back to school; he asked his younger brother to help him with his reading; he was looking forward to Christmas.

What was missing? What went wrong? And what errors have we corrected?

Walter was known to one agency all his life, the Department of Welfare (now the Department of Social Services), and to another from the time he began school, the Board of Education. The Department of Welfare, as far as the known record indicated, offered no special services either to Walter or his mother to help either one cope. The Board of Education, which first noticed how troubled he was when, at age nine, in the third grade, he roamed

the halls and threw temper tantrums his teachers viewed as "cries for help", also offered no help to the family. They did not refer Walter to the school psychologist or to the Bureau of Child Guidance. It is not known whether they ever even called in his mother to talk about his problems. The Board referred him to the Society for the Prevention of Cruelty to Children, which brought the family to court on a neglect petition. Although his brother Tony was placed, Walter was eventually released to his home. The record gives no indication of service to his mother to help her to cope, or to alleviate stress, and no effort to provide continuity of care by an adult more adequate than the mother.

Much could have been done at far less cost than the amount lavished so fruitlessly upon placement of Walter.

The most important thing in the life of a child is continuity of close relationship with a "parenting" adult. This was dramatically restated by Anna Freud and Joseph Goldstein in their recent book Beyond the Best Interests of the Child:

"Continuity of relationships, surroundings, and environmental influence are essential for a child's normal development. Since they do not play the same role in later life, their importance is often underrated by the adult world.

"Physical, emotional, intellectual, social, and moral growth does not happen without causing the child inevitable internal difficulties. The instability of mental processes during the period of development needs to be offset by stability and uninterrupted support from external sources. Smooth growth is arrested or disrupted when upheavals and changes in the external world are added to the internal ones."*

*Goldstein, Joseph, Anna Freud and Albert J. Solnit, Beyond the Best Interests of the Child, The Free Press, New York, 1973, pp. 31-33.

The Domestic Relations Court, and later, of course, the Family Court, recognized the central importance of this need. The purposes of the Domestic Relations Court of the City of New York were to "rehabilitate, reconstitute families, and reconcile differences in families with a view of reestablishing them", James v. James, 1941, 148 Misc. 1041, 37 NYS 2nd 89. This was restated in Tugender v. Tugender, Dom. Rel. Ct. 1942, 33 NYS 2nd 1003, in which the primary purposes of the court were said to include "the possible adjustment of dislocated human relations, possible maintenance of a family unit".

To help a troubled child and an inadequate or pressured family, one of the following, or both, are usually required: first, that the family learn new patterns of interacting and that the family members learn to cope more satisfyingly, to enlarge their opportunities for sociable gratification; and second, that help be provided to alleviate the external stresses.

When the family remains inadequate, it may be necessary to offer a continuing relationship with someone outside the family, someone to whom a child can turn through all the vagaries and pains of growing up. Meaningful help for a child must focus on strengthening his family and, when this is not enough, must provide a substitute "Rock of Gibralter". It is necessary, at times, to reinvent the parent.

The record of what was or was not done for Walter is not known in detail to this Commission. The portrait sketched in The New York Times does point up what we know to be general

defects in the system of delivery of care to troubled children, those on drugs and those not yet on drugs. These defects include:

• Failure to offer services which might strengthen the family. Such services might include family counseling, individual therapy, which, at its most expensive private rate of about three thousand dollars a year, is one fifth the cost of placement for one child. They might include homemaker service, which is a surrogate mother type service intended to pull together a disorganized home and give the parent a "breather". This, too, at a cost of about five thousand dollars a year, or perhaps six thousand dollars for a large family, is a far better buy than placement at fourteen thousand dollars per year per child. Such services might include <u>good</u> day care for a young child so that the parent can go to work, or to school in preparation for work, and regain his or her sense of self determination and control over his own and his family's life; or so that he or she might continue to work without his absence being a detriment to the child.

• Failure to keep siblings together, when placement is necessary. This failure was dramatic in Walter's case. His next oldest brother, Tony, the person to whom he had a continuing relationship, and who was concerned about him, tried in vain to interest the agency caring for him in his brother Walter. What grand design of society does it serve to separate two small brothers who might be a source of comfort and encouragement to each other?

• Inflexibility and lack of imagination in planning. The one place in which Walter reportedly did well was Patterson House,

where he found an adult he trusted, returned to school and attended regularly. He was moved from there, however, because Patterson is a halfway house for children who have been at Wiltwyck's upstate campus, who are in transition back to their homes. Walter was placed there to await the move to Wiltwyck, and was moved as soon as there was room for him upstate. Was any thought given to the possibility of simply leaving the child where he was, though he did not fit the category for which the house was intended? And what of the woman who viewed herself as Walter's godmother. Did anyone know she was willing to take in Walter, but needed more space? Could she have been helped to find such space, and to get an extra bed? Would she have been willing to parent Walter?

• Failure to provide one adult whom a child can trust, to see him through all his changes and strains. Walter's need for such a "parent" was clear, in his seeking out of the one counselor he loved, in his wanting even to go away with him. Such a parent can be a neighbor, a professional, a relative. He can come to know the child through an agency, as a staff member or a volunteer, or through a block association or neighborhood "big brother" group, or through a church or a P.T.A. But come to know him he must, because for those families who need this buttress, its absence renders everything else useless.

Since Walter Vandermeer died, some things have improved. There are now treatment centers for child drug abusers. Children's Center and Callagy Hall, both for neglected children, have been closed. The emphasis, at least for short-term care, is now on providing small group homes, rather than large institutions.

There is increasing talk about, and even some programs working toward, the reuniting and strengthening of families.

Reinventing The Parent

A substantial number of witnesses before this Commission described the destructiveness of the gulf between their young drug abusing patients, and such children's families. They complained that when they failed to win the family's cooperation, their efforts with the child were sabotaged or at best of limited value. Those treatment agencies which made an effort to involve families reported success in doing so in most cases, and increasing numbers of treatment agencies are making this effort. In Walter's day, the emphasis was on receiving the adolescent and working with him alone, identifying with his complaints about his family, its values, its ways of relating, and helping him "do his own thing". This was perhaps helpful in many cases, as far as it went. But where did the young person go after he left treatment? What really had changed? Of course a child must learn to recognize his own unique separateness, his own identity. Part of maturing is recognizing weaknesses of others in one's family and that early disappointments were not solely one's own fault. For an adult, one can leave it at that and go from there. But for a child there must be some parent. The family of choice is the child's own family.

How the attitute toward families of children in trouble has changed is described in Innovative Approaches to Youth Services,

in the context of work with runaways.*

Program staff find that working with runaways is a major learning and maturing experience. Initially, staff tend to identify with the runaway and to agree that the runaway's parents are in the wrong and that none of the problems are the adolescent's. The staff has a tendency to reinforce the runaway's perception and to agree that the parents are unjust and that the running away is justified. Since the staff consists of young people, their own problems with their parents are not that distant and help to influence their perception. When the parents are brought in for a counseling session with their teenager, the staff quickly learns that the problems are not so one-sided and that perhaps the runaway is also contributing to family conflicts. These experiences help the staff become increasingly more sophisticated in their counseling role and to take a more neutral, third party stance on problems.

Our whole concept of treatment, what you do when a kid comes in, is very different from our original stance. Initially we would come in and rap, and let a kid rap for hours and hours. Our counseling perspective was to be a friend to the kid. Anything a kid says is true; take a kid's word for everything; that's who you identify with. We've made a real swing to much better interviewing techniques to help the people who initially interview kids to get a real sense of where the problem does lie. Is it the kid who's in really severe trouble personally? Is the kid in trouble more because of the family dynamics? Is the kid really okay, with a family that's really in trouble? We try to pinpoint what the problem is.

Initially the staff feel that the runaway problem is not a psychological concern and are very much against clinical interpretations. The staff see the problem as mainly one of destructive parental behavior. As the staff begins to see the complexity of family problems, they become more clinical in orientation.

The staff started from an extraordinarily anti-psychiatry stance. Professionals didn't know anything; didn't have anything to tell them. They've become more sensitive to the child's needs; they've really learned a lot about psychodynamics. The staff now gets together twice a week and talk about each kid that's there. The counselors are sharing information with each other in order to

*Kolton, Marilyn, Ph.D., Dwarshuis, Louis, Ph.D., Gorodesky, Michael, M.S.W., and Dosher, Anne, B.A., Innovative Approaches to Youth Services, Stash Press, Madison, Wisconsin, 1973, pp 56-57.

help those particular kids.

Staff also become aware of how difficult it is to change family situations in which the members have a long history of destructive communication patterns. The need for follow-up work for both parents and adolescents is realized and more counseling is done after the adolescent returns home. If the family is not from the immediate area, the problem of counseling is greater and programs have to make referrals, with little assurance that the family will actually seek help.

Working with runaways results in the staff feeling some pessimism about family conditions and adolescent treatment. They become acutely aware of the lack of real help in our society for the young person who is having trouble with his parents. The adolescent has few legal rights and is often trapped in a highly negative and destructive living situation. There are few adequate treatment facilities for the disturbed adolescent or living arrangements for the adolescent who does not want to return home or live with a foster parent.

In Before Addiction: How to Help Youth, a book written for parents, the authors have these comforting words:*

A conflict between generations has always been a normal part of life. It comes about because of the necessary changes in adolescence to a new self in a different world than the parents knew. The world has always changed from one generation to another, even if at some times and places the changes appear slower and more gradual--usually only in historical perspective.

Peter Blos, an analyst of the phenomenon of adolescence, suggests that the notion of "generation gap" is a device used to create so vast a distance between young and old, that they become incapable of meeting in either mind or body. As a consequence the conflict between generations that is essential for growth both of self and of civilization is avoided.

Disagreements between you and your child will not hurt him. They are inevitable and in the long run help him define the differences between you and himself, one of the very

*Lieberman, Florence, D.S.W., Caroff, Phyllis, D.S.W., and Gottesfeld, Mary, M.S.W., Before Addiction: How to Help Youth, Behavioral Publications, New York, 1973, pp.46-49

important tasks of his adolescence. As he works through these areas of conflict with you and with other representatives of the older generation in the larger society, he helps to define himself, his values, and needed changes in the larger world. He can refine his ideals and develop his philosophy.

If there is no conflict, if you understand everything, accept and agree with all he does, you leave little for him to learn to understand by himself. His identity loses its clarity and its strength.

The dilemma of the generation gap is not yours alone; the glorification of the youth culture is part of today's scene and involves the total society.

THE EXPERTS

The experts in education, the social sciences, and the "helping" professions do their bit to widen the gap. It seems that often in their struggle to both understand and provide adequate social arrangements for helping young people to grow, they tend to undermine the appropriate role of parents. They neglect to use their combined resources of values and knowledge to encourage connectedness between parents and their adolescent children. Too frequently there is failure to question who has expertise for what and to acknowledge the incompleteness of what is available in the realm of fact. More often than not, the focus is on parental weakness, rather than supporting the positive potential of parents who should be encouraged to trust themselves.

What you find in the literature does little to support your image as helper to your children. In addition to reinforcing your sense of hazard, you find spelled out and underscored all of the potentially pathological hurdles you present to your children, or scientific instructions that thoroughly negate either your individual needs and problems or those of your children. Unfortunately, so much of the literature is focused on psychopathology, and so little recognizes that you also have the capacity to master the challenges presented by your children's growth.

To expand on your very real dilemma, you need only a cursory review of the mass media--television, popular magazines, and the press--and the professional literature of psychiatrists, psychologists, social workers, other mental health personnel, and educators. All dramatically define adolescence as a developmental phase fraught with danger. The emphasis is on the high potential for psychological maladjustment and destructive social behavior.

In essence, though the tasks of separation and individuation from the family are critical in the process of becoming an adolescent and moving to adulthood, this process must be differentiated from alienation. The process of individuation necessarily includes both you and your youngsters as the actors. Alienation involves the withdrawal of essential emotional caring and trying. Talk of alienated young people concerns their resignation and hopelessness. Alienation that involves parents themselves appears to be a reaction to the separation and individuation process of their children, when the parents have given up all hope for communication and when connectedness has broken down.

Too many of you today anticipate your children's adolescence with apprehension. You do not have to feel hopeless and helpless. The large majority of our young people work out relationships with adults, perhaps different ones from those of the past or future. But very frequently they incorporate parental values. There are many studies comparing adolescents' beliefs with those of their parents which attest to the similarity in their values, despite highly publicized opinions to the contrary.

A trusting relationship between you and your child is necessary to his learning how to be an adult. Conflict and difference of opinion need not undercut trust. The stereotype of adolescence as a sorely troubled period is interfering too frequently with your expectations that your children will make it. Without talking simplistically about the power of positive thinking, there is much evidence to support the sociological concept of the self-fulfilling prophecy. It stands to reason that an apprehensive climate of expectation increases anxiety and tension. If you are living with such apprehension, you must of necessity struggle with feelings related to flight, or alienation.

Your ability to maintain connectedness in feeling with your children is important in helping adolescents. Sometimes this involves remembering the fears, doubts, and struggles of your own adolescence by way of increasing your understanding of that with which your children are struggling. Meanwhile, you still have to know your present feelings, attitudes, and values, as parent and adult.

For some of you knowing your real feelings and knowing who you are is very difficult. Partly this occurs because of the cultural emphasis on youth which has further worsened your conflict and confusion. Some of you, like all of us today, want so much to be young, and may have worked overtime to demonstrate your ability to diminish generation differences. Not only does this dull who mom and dad are,

but it adds to the anxieties of the very youngsters whom you would like to resemble. It is simpler for a young person to deal with prohibitions and taboos than with contradictions, confusion, and inconsistency.

Two Programs Which Reconcile Families

Since treatment agencies are more and more aware of the need to reconcile the children they treat with the children's families, they have begun to develop varying modes of involving the families. The variations reflect different styles and different philosophies, which are geared to families with different life-styles, and employ different kinds of staffs.

Some of the programs which consider themselves "innovative", rather than traditional social agency settings, primarily the "walk-in" or crisis centers, have developed imaginative ways of reaching out to the parents of their children and to other adults in the community.

Innovative programs find themselves becoming increasingly involved with parental and adult problems. The case of the runaway and concern about their children's use of drugs are two good examples of ways programs have to interact with adults.

> Parents are always a hassle. We feel it's not thorough enough to talk to the kid and counsel him. He goes home to the place that perhaps was responsible for the problem. So we want to talk to the parents and get them involved.

Another source of contact with parents is through adult volunteers who are having trouble with their own children. Often staff find that the adult problems might have little or nothing to do with the adolescent's problem. Many adult problems are individual psychological problems, marital conflicts, or alcoholism. As a result of this growing awareness of adult needs, innovative programs are becoming more involved with programs for adults. Many programs hold parent counseling groups. Parents originally come to these groups expecting to learn how to cope better with their adolescent. They find they learn more about their own problems.

> We've been running special groups of parents for about a year now. We had trouble getting them to come down; maybe one, two, or three parents would come down. We'd run these groups for ten weeks and then start a new group. We never had a parent stay who wasn't just really overwhelmed. They come to it with all kinds of misconceptions, but they got something out of it. It turned out they liked it. They would tell other parents, so in the next group we would have seven or eight parents and so on. The most interesting thing was that we really didn't have a structure of objectives, other than to get the parents to talk about their families and their kids and drugs. The orientation was toward drugs, but evaluations were undertaken last year, including the parent's groups and use of pre-tests and post-tests over a year period. The post-tests indicated that the clinic had helped parents most often in learning about themselves--not about kids, drugs or the community, but about themselves. The parents said that. It's incredible. I was really amazed. But they actually learned something about themselves. One guy discovered what he was doing to get his wife uptight, and that he hadn't talked to his wife in twenty years.

One program reported beginning a housewives group. Several programs developed auxiliary programs for parents. One especially interesting program is run by parents for parents. They provide a phone service which they call a "panic line". Parents having problems with their children or wanting drug information can call and talk with a parent who probably has had a similar experience. This parent's organization also conducts its own parent's groups as a means of providing follow-up counseling. Programs find that work with parents can also increase their credibility in the community.

> One of the best things that we've ever done is through this auxiliary. They had community coffee meetings just for parents in the community, in their own neighborhood. They were held in their own homes. The staff would come and answer their questions and meet the people. Some we'd win over, and some would be neutral, but they were not able to believe rumors and misunderstandings that they had come to the meeting with. We were right there, and they

> saw other parents saying, 'Listen to him; they're not doing all those things.' And it's become a force in the community itself. The city councilman can't say that these long haired freaks don't know what they're doing. Their own constituents are helping us in the community.*

At Southeast Nassau Guidance Center (SNG Counseling Center, Inc.) staff uses a more traditional mode to resurrect a forgotten art, that of enlisting the help of a family in the cause of its child. That program, and the background of it, were described to this Commission at its hearing on Treatment of Drug Abusers in Nassau on September 5, 1974, by Dennis M Reilly, C.S.W., A.C.S.W.

I. BACKGROUND:

The mental health field, Mr. Reilly pointed out, has come to realize that the pathology manifested by the "designated patient" is often, if not always, a reflection of the interpersonal pathology prevalent within his family. Yet this insight has not been widely applied in the field of drug abuse. Family therapy as a treatment modality for youthful drug abusers and their families, for example, is a surprisingly underutilized technique. Too often, drug counseling programs accept the "myth of the designated patient" and assume that the drug abuser is the only "sick" family member, the only one needing help.

The process of labelling the drug abuser as the "patient of record" begins in the family or the criminal justice system, gains momentum when he and his family are interviewed separately

*Kolton et al, op. c.t. pp. 58-59

on admission to a residential treatment center or to outpatient therapy, and bursts into full steam when the drug abuser is diagnosed and assigned to a treatment regimen--while the other family members either remain untreated or are treated separately as "non-patients" in parental counseling or some similar approach.

All too often, counselors who have contact with the families of youthful drug abusers see family members in an extremely stereotyped or one-dimensional way--either as merely convenient storehouses of information about the drug abuser or as villains who somehow "made the patient sick". Consequently, the families are often denied the counseling help they desperately need, despite the fact that the drug abuser will often eventually return to live within this same disturbed family system which helped to produce his symptoms in the first place.

II. HYPOTHESIS:

SNG believes that intrafamilial dynamics play a very large role in both the development and maintenance of drug-abusing behavior. Staff there does not, of course, discount the importance of extrafamilial or non-familial factors in drug abuse--they recognize, for example, that social class, subculture, and peer group membership are all influential in determing whether drug-using behavior is defined as an avenue of social conformity or deviance for the group or family in question. But, especially in the case of youthful drug abusers who are living at home

with their families, they believe that drug-abusing behavior is, above all, a family pathology, a symptom of family system dysfunction. They therefore see family therapy--meeting the drug abuser together with all the members of his family simultaneously and on a regular basis--as the treatment modality of choice. This form of intervention not only recognizes the familial factor in the deviant behavior, but it also involves the drug abuser and his family in a collective struggle to improve the quality of their intimate relationships and day-to-day social environment.

III. THE FAMILIES OF DRUG ABUSERS--INTERACTIONS:

At SNG Counseling Center many youthful drug abusers and their families are seen over extended periods of time in conjoint family therapy. As this clinical experience accumulated, staff began to notice that the families of drug abusers tended to share certain very definite and very characteristic ways of relating.

The Center recognizes, of course, that its sample was limited. The patient-population is drawn from Southeast Nassau and is therefore largely middle-class. SNG also recognizes that the traits these families share are probably present in all families to some degree--but these families carried these trends to extremes. Mr. Reilly noted he must generalize the Center's findings with caution--but believes that they are generalizable.

Drug-abusing families in their population often manifested the following characteristic traits:

(A) NEGATIVISTIC INTERACTION--Life in these families tended to have a dull, deadened, lifeless, shallow, affectless quality--as if each member were encapsulated and living alone in his own world. Family members communicated primarily negative messages (criticism, nagging, complaints, warnings, etc.) to each other, when they communicated at all. There was rarely any praise for good behavior--acceptable behavior was ignored while negative behavior was unfailingly reinforced with attention. All family members found it very hard to express any positive feelings (love, concern, tenderness) for each other. Children learned early that the best way to get attention was to cause trouble--"the squeaky wheel gets the oil". Even if it meant a beating, at least one could get some attention by "being bad". Such families seemed to thrive on crisis, to only "come alive" in disaster. Their members were highly ambivalent about intimacy--they were also terrified of emotional closeness.

(B) LACK OF CONSISTENT LIMIT-SETTING--The parents in these families seemed incapable of setting consistent limits upon their children's behavior. Often parents would disagree over whether or how to discipline the children, and behavior that would be rewarded or ignored one moment might be punished the next. The children received very confused and mixed parental messages concerning right and wrong.

(C) A CRY FOR HELP--Under such conditions, the children often desperately attempted to provoke their parents and other authority figures to impose firm and consistent limits and moral standards.

Thus, youthful drug abusers from such families often unconsciously "set themselves up" to be caught by leaving "clues" and escalating their disturbed and self-incriminatory behavior. Their drug abuse was almost flaunted in an attempt to invoke adult attention, concern, and intervention.

(D) MASSIVE PARENTAL DENIAL--Despite the many "clues" drug abusers often left for their parents, parents just as often somehow managed "not to see" the clues, to deny the drug-abusing behavior until forced to face it by outside authorities or by near tragedy.

(E) VICARIOUS PARENTAL BEHAVIOR--One reason that parents do not always intervene early and forcefully in their children's drug-abusing behavior is that often the parents themselves have an unconscious investment in their children's deviant behavior. Some seem to get vicarious gratification from their children's actions --in a sense, the children are acting out the parents' own unconscious desires. Though such parents often overtly denounce "youth's new freedoms" (sex, drugs, etc.), they often unconsciously envy them and communicate this feeling to their children. The children are often given tacit permission to use drugs in one way or another.

(F) DIFFICULTIES CONCERNING ANGER--Family members tend to see any open expression of feelings as dangerous--especially anger. In such families where love is rarely shown, people tend to feel very emotionally deprived and angry. Often, their hurt and rage are so great that they fear they will "lose con-

trol" of their anger, "go crazy", or "kill someone". Because of this fear, the anger is often suppressed, "driven underground".

Seeing himself as a "potential murderer", the young person in such a family often feels it is essential to inhibit all direct expression of anger towards his parents. Instead, the anger gains expression in a delayed or indirect fashion--

(1) through displacement, in which authority figures, siblings, or peers, instead of the parents, are attacked;

(2) through passive-aggressive behavior--as in drug abuse, when the youth turns to drugs partially in an unconscious attempt to " spite" the parents and take revenge upon them for their unkindnesses. Drug abuse is frequently a thinly-disguised hostile-rebellious act--sometimes even symbolically murderous, judging from the number of young people who remark, "If my parents knew I used drugs it would kill them";

(3) through intropunitive behavior, in which the rage originally felt towards the parents is turned inward against the self. This is very common in drug abusers and leads to a more or less chronically depressed state, a lowered self-image, and a self-punitive and a self-defeating life-style. Along with this intropunitive trend, there are frequently manifestations of "accident-proneness", suicidal ideation/gestures/attempts, "masked" suicides (as in many overdose deaths), and psychosomatic illnesses.

(G) DRUG USE AS "SELF-MEDICATION"--Members of these families regularly experience feelings of mutual alienation,

loneliness, meaninglessness, rejection, abandonment, loss, deprivation, guilt, anxiety, rage, depression, and worthlessness. They often defend against these unpleasant affects via self-medication. Rarely is this defense confined only to the so-called "drug abuser" in the family--more usually, almost every family member relies heavily upon the compulsive ingestion of mood-altering substances--from legally-prescribed or countertop tranquilizers, sedatives, or stimulants to heavy alcohol consumption, smoking, coffee-drinking, or even overeating. Substances are consumed to bolster flagging self-esteem and to help prevent the family members from feeling the anguish of emotional abandonment, separation, and loneliness. They serve as anaesthetics, as tranquilizers, as antidepressants. They may also be used as disinhibitors--in such cases, members feel they can only break out of the stultifying atmosphere of the family when they are "high"--only when they are "not themselves", only when "under the influence", do they feel free to express real feelings, confront real issues, and act creatively and spontaneously. In these instances, drug use is a miscarried attempt to be "real", to feel human, if only momentarily and if only through artificial means. "Getting high" often means not only a temporary surcease from psychic pain, but also, in fantasy, a symbolic reunion with the loving, warn, caring "good-mother"--a womb-like feeling of well-being markedly absent in the gnawing emptiness of everyday family life.

(H) PATHOGENIC PARENTAL EXPECTATION--Parents of drug abusers frequently either expected too much of the drug-user, expected the worst of him, or shifted back and forth between unrealistically high expectations and extreme pessimism. In any case, the drug abuser was placed in a "no-win" situation. In cases where the parents expected perfection, where love was conditioned upon success, the child would develop fear of failure, repressed rage, inferiority feelings, and marked insecurity. Often he would avoid trying a task at all because trying entailed the risk of failure. Paradoxically, often he would perceive drug use as a handy way of minimizing the risk of failure--after all, what could be expected of a drug abuser? Drug abuse could also serve as a way of getting revenge on the parents and it embodied the idea, "If I can't be perfect, at least I can be 'perfectly' obnoxious". In cases where parents initially expected the worst of their offspring, the children would become enmeshed in this self-fulfilling prophecy--often they would try to "please" their pessimistic parents by "living down to" their low expectations. They clearly got the message that on some level their parents wanted (needed) a "junkie", alcoholic, or "pothead" in the home and they did their best to comply. Essentially, they were following a negative life-script written by their parents, and the script called for their command appearance in the role of "family blacksheep" and/or "scapegoat".

IV. THE FAMILIES OF DRUG ABUSERS--INTERGENERATIONAL DYNAMICS:

The compulsive use of drugs (including alcohol) by a young person in a family generally indicates a disturbance not only in the youth himself, but also in his parents, their personal backgrounds, and their marriage, according to SNG.

Generally, the parents of drug abusers seemed to be people in mourning. Usually one, or more commonly, both parents have sustained profound emotional losses within their families of origin--a father or mother has been lost via death, divorce, desertion, rejection, etc. Characteristically, the parents of the drug abuser have never adequately resolved their hurt, anger, or guilt over this loss. The shadow of their grief hovers over all their later relationships. When they marry, they often choose a mate whom they hope will somehow recreate both the good and the bad qualities of the mother or father they feel they have lost. This search for a "replacement" invariably leads to a disillusionment and to marital conflict. When children are born, they too are seen less as individuals in their own right and more as substitutes for, or "reincarnations" of, the lost grandparents. By remaking first his spouse and then one or more of his children into images of his own lost mother or father, the parent need never fully experience the dreaded pain of separation, loss, and completed mourning. Unfortunately, relating to one's spouse or children as if they were really one's parents creates more problems than it solves. When children are thus "parentified" the real parents lose their authority and ability to set limits;

they turn to their offspring for direction and as allies against the spouse. Relationships become hopelessly confused, generational boundaries are blurred, and the family members tend to lose track of where they begin and others leave off.

Marital conflict is ever-present in such families but it is not always overt--it is more often denied and masked by "behavior problems" in the children. Actually, the "children's problems" (e.g.--drug abuse) are often reactive to the marital schism, and represent an attempt to "save the marriage" by diverting parental attention from the failing marriage--essentially, the children offer themselves as sacrificail scapegoats in this situation.

Parents who have never adequately mourned or accepted the loss of their own parents are usually unable to tolerate the loss of separation from their children. Anxiety about separation in such families is quite high and is clearly conveyed to the children from infancy onwards. Developing individuation and independence on the part of the children is generally discouraged, since individuation tends to be equated with separation, loss, and death. Thus, despite the deceptive surface appearance of mutual isolation, encapsulation, and noninvolvement given by these families, the members are, beneath this facade, strongly bound to each other and enmeshed in "sticky" ambivalent ties.

It is precisely these central underlying conflicts around attachment and separation, loss and replacement, which operate to move children into the drug-abusing role. Whatever

their conscious attitudes towards drugs, the parents of many drug abusers have a very strong unconscious investment in their children's becoming and remaining drug abusers. Often a family "needs" the young person to use drugs so that he will better fit into an assigned family role as the "blacksheep" who reincarnates a lost one or who embodies a parent's own disowned impulses. In other cases, his drug abuse serves the family well by assuring that his "sickness" will keep him indefinitely dependent upon his parents, thus assuaging both his own and his parents' separation anxiety. As long as his drug abuse serves to maintain the existing family balance, to maintain relationships as they are, and to guard against loss or the recognition of loss--as long as these conditions are met, the family system will have a powerful unconscious commitment to maintaining the symptoms, regardless of conscious protests or declarations to the contrary.

These families can "live with" drug-abusing behavior--indeed, they may even subtly encourage it, as long as it helps to keep the family together, to prevent individuation, and to maintain everyone in his assigned role. It is only when the drug use in redefined as a "revolt" by the young person, only when he uses it in an attempt to establish his own identity <u>apart</u> from his family, only when he uses it to <u>break out</u> of his traditional family role, that drug abuse is perceived as a true threat and an evil by such parents. In these families, behavior which promotes fusion is "good", whereas acts which threaten separation are "bad".

V. FAMILY THERAPY IN DRUG ABUSE:

In cases of true drug (or alcohol) abuse--where a person regularly and compulsively uses drugs, as opposed to occasional or experimental use--staff at SNG believe that psychotherapy should always be an option for the user. And in those cases where the user is either living with, or intimately involved in a family unit on a more or less continuous basis, they would advocate family therapy as very often the treatment of choice. They find that outpatient family therapy, especially with younger adolescents and those on "soft" drugs, can be very helpful--indeed, it is often superior to individual and peer-group counseling. And even for those "into" harder drugs and those already placed in residential treatment facilities, regularly scheduled family sessions can be invaluable, not only in helping the drug abuser to learn to cope with the family stresses which may have motivated his drug use, but also in assisting the family to improve its functioning as a whole. This is especially important if the discharge plan involves the drug abuser's return to his family, Mr. Reilly testified.

Family therapy can be effective used either alone or concurrently with other treatment modalities such as group or individual counseling, or methadone maintenance.

In conjoint family therapy, a trained family counselor meets with the drug abuser and all the members of his immediate household in regularly scheduled sessions--usually held once or twice weekly, and lasting at least an hour each.

In multiple family therapy, three or more drug abusers and their respective families meet together with one or more family counselors on a similar scheduled basis--common problems and situations are shared and solutions are suggested. The families which may not have been able to help themselves in the past, gradually become able to help each other.

The experience of SNG indicates, Mr. Reilly believes, that once we redefine "the problem" as the family and the way it relates, once we identify it as interpersonal rather than solely a "personal" problem of the drug abuser alone, then we have opened the way to significant changes in the entire family. Therapy can be quite successful in helping families to alter unhealthy patterns of relating. Families can be taught, for example, how to "accentuate the positive" rather than the negative aspects of relationships; parents can be helped to set consistent limits and family members can be trained to listen to each other's feelings and hear each other's "cries for help"; parents can be helped to complete their mourning for the loved ones they have lost, thus finally laying to rest the ghosts which seem to haunt these families. As treatment assists family members to see each other as real individuals with the right to express real feelings, the family's need for a chemical crutch diminishes. In cases involving younger drug abusers, even short-term family therapy, time-limited at 15 sessions, can so alter the family balance that compulsive drug use may disappear completely as a symptom.

This center finds family therapy to be highly practical, both in its economy and in its preventative value. It is economical because it allows them to treat several people at once, and it is preventative in that it not only ameliorates the drug abuser's social environment so as to forestall relapse, but it also assists the entire family to reach a higher level of adjustment--thus helping to prevent future breakdown on the part of any other family members.

In discussing the professional problems associating with family therapy, Mr. Reilly testified as follows:

"Mr. Dennis Reilly: I think that basically, in the past, a lot of times all of us have been looking for the one true cause of drug abuse, or the one best treatment for drug abuse, and the fact is that we are learning that there is no one cause, and on one treatment. We are realizing that a treatment must include a broad gamut of activity ranging from changing the laws and society, to changing the individual drug abuser, and the social environment.

"In the past a lot of drug treatment programs kind of stressed the use of encounter groups, and methadone maintenance, and the therapeutic community. They have achieved some success with these approaches, but other forms of treatment have been under-utilized and one such form, I think, is the family therapy...

"What other drug programs have often done they have accepted the myth that the kid using drugs is the only one in the family that needs help, and he is the problem and the client, and

the patient, and the family is sometimes ignored....

"Mr. Hollenberg: Are there any ideas that you might have for attracting more families as a group?

"Mr. Reilly: Well, what we have often done is said to the parents that the best way we have of treating, or of helping your son or daughter is for you all to come in because that problem seems to be affecting all of you in the family and not just him. It is bothering you just like it is bothering him and that is our hook to get them in.

"Sometimes we said that we can't really successfully treat their child unless they participate and unless they come in. We don't want them to be excluded. We see it on a positive basis and it is important for them to be here, and they can contribute....

"I think that there are a lot of times when a parent, as much as a child, is very anxious about coming in. You see the same thing in families of alcoholics where over the years the people have achieved a way of relating. It is hard and the skill is in trying to get them in and keep them in, and it is not easy, and we are not always successful".

Reinventing Extended Families

While the above described family therapy is a treatment modality which this Commission is convinced should be more widely practised, what of those one-parent families who are isolated in homes to which they have recently moved, or who find themselves forced to move so frequently that life becomes rootless? Some concrete underpinnings need to be offered to them, either instead

of, or along with, or before family therapy.

Eighty-four percent of children from single-parent families live in a home in which it is the mother who is the head-of-household. In the last 13 years (1960-1973), these woman-headed single parent families increased from 1.9 million to 3.8 million. In the past three years alone the number of such families with children under 18 increased by thirty percent.* More than half the children in these families live below the poverty line.

A number of experimental programs, often of a self-help nature, are intended to provide the family, and therefore indirectly the children, with the kind of back up support traditionally available from members of the extended family--grandparents, aunts, uncles, cousins, siblings. These have been discussed extensively in prior reports of this Commission and of its antecedent legislative committees. Many of these were discontinued, as volunteers tired. These programs offer aid in emergencies, staying with the children if the parent needs to be hospitalized; babysitting while the parent markets; offering comfort and companionship to lonely adults who carry the load of constant care for their small children. It is possible to expand the services of centers to include a great deal for the

*Whaley, Betti S., Commissioner, A Public Service Employment Program For Women, informational paper issued by the Agency for Child Development, New York City Human Resources Administration

working parent. To work hard all day and then pick up one's child, cook dinner, bathe the baby, wash the clothes, iron a shirt for school can be disspiriting when one is always alone. Community centers, or even churches and parish halls could offer to such a parent the option to pick up a ready-cooked dinner at cost, or to share a communal kitchen or laundry room, so that the parent can work with company while the child, perhaps, does homework with supervision. City living, with its frequent isolation and mobility, requires such services. The informal avenues of cooperation and mutual aid are often excellent in the inner city. Sometimes, however, as was the case with Walter Vandermeer's godmother, cramped quarters, a shortage of beds, lack of money make it impossible for even willing neighbors to help each other and each other's children.

RECOMMENDATIONS

This Commission finds that at times the Family Court is used as a first resource rather than a last resort; and that the Court process established for the purpose of strengthening families, yields the opposite result. Services are rarely offered to a family prior to the decision to place a child away, which should be a last decision when all else has failed. Services are almost never offered to a family while a child is in placement, so that upon his return the family will be stronger. This Commission finds that children must fit into categories, that resources are not used creatively and imaginatively to fit the child, that re-

lationships within the family and the neighborhood which might sustain a child are not utilized. Even more--they are often broken.

This Commission finds that in the absence of a real effort to shore up families, funds spent on treatment of child drug abusers are often wasted.

Therefore, this Commission recommends:

1. Funding for research and pilot programs exploring the use of family counseling, including family therapy. Guidelines should encourage the inclusion of family counseling services in drug programs, or in a nearby community facility working cooperatively with the drug program.

2. A training program in family counseling and family therapy skills for both professionals and paraprofessionals in the drug abuse field.

3. The encouragement of family therapy and family counseling in present neighborhood based facilities, public and private, such as community mental health centers, other Health Maintenance Organizations, community centers, churches. Such services can be publicized through P.T.A.'s, neighborhood associations, narcotic guidance councils.

4. Families should be kept together. We recommend:

a. That placement should be viewed as a last resort. Placement should be viewed as a temporary condition, with the expectation acknowledged that eventually the child will return to his family and the family should be prepared to cope with him

constructively.

b. The provision of concrete services to strengthen the families of children in trouble, those using drugs and those expressing their troubles in other ways.

c. Imaginative and creative planning by social service professionals, to use the assets available to a child, such as relatives and neighbors who care about him.

d. Neighborhood based service centers of various kinds do exist. Their work should be coordinated, so that cooperatively in the aggregate they offer a comprehensive range of services.

e. Coordinating programs which service the senior citizens with those which service families. A major problem with senior citizens is their sense of valuelessness and loss of self esteem when they retire or when their children are all grown. Children and young parents in the inner city suffer from the absence of grandparents, aunts and uncles. If the two groups can come together, both gain.

5. When Placement is necessary:

a. There should be flexibility in the use of resources, including placement resources, so that each child's plan is tailored to his needs, not the agency's.

b. When placement of more than one child in a family is necessary, the siblings should be placed together.

6. Acceptance of responsibility for a child by one agency, and when possible one social worker, on a continuing long

term basis, no matter where that child is living, until he or she has been launched on a life-program which is satisfying to him and to society. The model for this assumption of continuing responsibility exists in jurisprudence. A Judge can assume continuing responsibility for a case, and that case will then return to that Judge for review and supervision at any time in the future. It is high time that the social work profession recognized how essential it is to the well-being of a child that there be one helping adult to whom he can turn whatever vicissitudes of life assail him. There is nothing in law or guidelines preventing the assumption of such responsibility for each child. In point of fact, in many cases, as in Walter Vandermeer's, prime responsibility for the family does rest with one agency, the Department of Social Services, from the child's birth to maturity. That department even in some cases has statutory responsibility to supervise the services offered that child by other agencies, because it must approve reimbursement to such agencies. What is missing is the <u>personal</u> responsibility of a single worker supervising, in substance, not form--a worker who knows the child.

VII. Obituary of a Heroin Addict Who Died at 12

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Walter Vandermeer — the youngest person ever to be reported dead of an overdose of heroin here — had been identified by many of the city's leading Social Service Agencies as a child in desperate need of care, long before his body was discovered in the common bathroom of a Harlem tenement on Dec. 14, two weeks after his twelfth birthday.

For most of these Agencies, he never became more than one case among thousands passing through their revolving doors. Others tried to fit him into their programs, but lacked the manpower or resources to focus on him effectively. Eventually he would be shunted off to yet another institution.

It was not heartlessness or malfeasance that explain why he usually went unnoticed, just overwhelming numbers. As one school official expressed, "There are thousands of Walter Vandermeers out there."

Along the way his case was handled by Family Court, the Society for the Prevention of Cruelty to Children, the Department of Social Services and its Bureau of Child Welfare, the Board of Education's Bureau of Attendance and the Bureau for the Education of Socially Maladjusted Children, the Wiltwick School for Boys and the Office of Probation.

Most of these agencies refused to discuss their actions in the case on the ground that their relationship with the boy was confidential.

But, interviews with neighbors, relatives and individuals in the schools and agencies through which he passed have made it possible to find a foothold in a world that always seemed to him on the verge of collapse.

The agencies had exhausted their routine procedures, before he died; only his file continued to move. For his last 14 months he was left to himself, with no consistent supervision or counseling of any kind, on the decaying block where he lived most of his life and died — 117th Street between Eighth and Manhattan Avenues.

There he was in intimate daily contact with addicts and pushers, as if none of the overstrained agencies had heard of him, or even existed. After his death, one of the junkies paid him this discerning tribute: "Walter lived to be 30 in 12 years. There was nothing about the street he didn't know".

Cupcakes and Coca-Cola

In those months he slept at home only sporadically and attended school for a total of two and a half days.

Walter would be out late at night hawking newspapers in bars or begging for coins at the corner of Eighth Avenue. In the daytime, when most children were in school, he would station himself near a radiator in a grocery store for warmth until chased or borrow a couch to catch up on the sleep he had missed.

His diet was made up of Yankee Doodle cupcakes, Coca-Cola and, when he had the change, fish and chips.

It was a life of frightening emptiness and real dangers. The only regular thing about it was a daily struggle for survival.

"Walter didn't do too bad," a junkie on the block remarked after he was dead.

"He didn't do too good," retorted a black youth, full of bitterness over what heroin has done to Harlem. "He won't see his 13th birthday".

"He didn't do too bad," the junkie repeated. "He looked after himself".

A Family Court judge, charged with the responsibility of saving such youths but lacking in most cases the means to do so, despairingly reflected:

"At least we knew about this one. There are many we haven't even counted yet. That horrible feeling just drives me crazy in the middle of the night."

The one thing the court and the various agencies to which it referred his case never knew — but might have suspected had they checked more closely into the circumstances of Walter's life — was that he was experimenting with drugs.

But even this probably would not have mattered, for no treament centers have yet been authorized here for narcotics users under the age of 16, although youths under 16 are dying in this city of heroin overdoses at the rate of one a week.

Anger and Fear

Two sides of Walter Vandermeer are remembered on his block.

One was the apprentice hustler, an angry, mistrustful youth given to violent rages in which he hurled bottles and flayed about with iron pipes.

The other was the small child who cried easily and searched continually for adult protection and warmth. Some of the older addicts, into whose orbit he gravitated in the last months of his life say he would sometimes call them "Mommy" or "Daddy" and fantasy a household into which he could move as their child.

"Walter wanted a lot of attention," said his oldest sister, Regina Price. And there were those in his family and neighborhood who tried to extend it, when they could. Given the stress of their lives, that was only now and then and never for long.

Survival on 117th Street is a hard proposition at best, and Walter's circumstances were already far from the best when he was born December 1, 1957.

His mother, Mrs. Lillian Price, had come to New York from Charleston, S. C., with her husband, Cyril, in 1947, when she was 22. Her schooling had never got beyond the third grade and she was on welfare within a year. (21 years later, she is still there).

In 1949 Mrs. Price had her first children — twins — and her husband moved out.

By 1957 she was, in social-work jargon, the nominal head of a growing, desperately disorganized "multiproblem" family. Walter was her sixth child; there had been four fathers. Five more children (one of whom died in infancy) were to be born in the next seven years to Mrs. Price and a Liberian immigrant named Sunday Togbah.

Father Deported

Walter's father, known variously as Robert or Willie Vandermeer, entered the country illegally from Surinam, having jumped ship here in 1947. Six months after Walter was born, he was found by immigration authorities while he was working as a counterman at a midtown pharmacy and deported.

But by then, it appears, Mr. Vandermeer and Mrs. Price had separated, for hardly six months after he left the country she gave birth to the first of six children she was to have with Mr. Togbah.

Only one other Vandermeer was left in the family, a brother, Anthony, three years older than Walter.

In those days, Mrs. Price and six of her children were squeezed into one room of a three room apartment at 305 West 117th Street they somehow shared with a couple with two children of their own. (Another of Mrs. Price's children, a daughter named Beverly, was being raised by a friend.)

According to the recollection of neighbors, Walter was sniffing airplane glue by the time he was 6 and sitting in on card games on the stoops when he was 8. In school he was marked as a disruptive child who could not be contained within a classroom's four walls unless permitted to fall asleep, which he did regularly, a sign to his teachers that he was staying out nights.

Aggression Flared Out

Public School 76 on West 121st Street gave up on him in early 1967, when he was in the third grade, soon after his ninth birthday. Walter had been out of school more days than not that year. When he was there he seemed locked in an aggressive pattern, roaming the halls and throwing punches at teachers who sought to restrain him.

Sometimes his violence could be seen as a stifled cry for attention and help. On one occasion he stormed out of an art class, only to fly into a rage because his teacher had not pursued him.

Walter was repeatedly warned to behave better, then suspended on March 2, 1967. It does not appear that the school ever attempted to arrange psychological consultations for him or his mother with the Board of Education's Bureau of Child Guidance.

After Walter's death, Assemblyman Hulan E. Jack was to charge that the school had "put the child out onto the street".

In fact, it did just the opposite by referring his case to the Society for the Prevention of Cruelty to Children, which then brought it up in Family Court on a neglect petition. However, had the Assemblyman's charge been correct, the result could hardly have been worse.

Placed in Queens Shelter

On March 14, both Walter and his brother Tony, the two Vandermeers, were placed in the Society's Children Shelter in Queens. Later they were shifted from there to the Children's Center at Fifth Avenue and 104th Street, which is run by the Department of Social Services for children neglected by their families.

An attendance teacher, as truant officers are now called, had singled out the older boy as a youth of unusual intelligence and promise. Six months later, Tony was assigned to a home operated by a private agency in Yonkers, where he had made what is regarded as a highly successful adjustment.

But Walter got lost in the judicial maze. While one branch of Family Court found Mrs. Price unable to care for Tony, another decided in August to release Walter — the younger and more disturbed of the two boys — to her care.

Releasing Walter to Mrs. Price was tantamount to releasing him to the street (by now the family had shifted to a top-floor apartment at 2124 Eighth Avenue, near 115th Street.)

The court expected Walter to go to Public School

148, a special school for disturbed and socially maladjusted children at West End Avenue and 82nd Street. But there was no response to repeated notices sent by the school to the boy and his mother.

Meantime, members of the family recall, Tony was attempting, without success, to interest the agency that looked after him in his younger brother's plight.

Stranded, Walter at 10 was reaching for his own solutions.

One involved Mrs. Barbara Banks, who had regarded him as a godchild ever since she accompanied Mrs. Price to the hospital at the time of his birth. Around Christmas, 1967, she said, she told Walter he could move in with her and three of her children, since her eldest son was going into the Army.

"A whole lot of people told me 'Ain't no hope for that boy,'" she said. "But I believed I could save him. He was so inquisitive, he could have been anything".

Although Walter eagerly seized the invitation, she said, she was soon forced to withdraw it, for her son was never inducted. Walter felt rejected.

Late one night he made that clear in his own way by hurling a bottle through Mrs. Bank's window, raining glass on her bed.

The boy spent most of his time on the streets until April, 1968, when the Family Court assigned him to the Wiltwyck School for Boys, a treatment center for disturbed youths from the slums that had basked in the patronage of Mrs. Eleanor Roosevelt and boasted such alumni as Floyd Patterson, the boxer, and Claude Brown, the author of "Manchild in the Promised Land".

The idea was to place Walter at the school's main center at Yorktown Heights in Westchester County, but the center was full and cutting down on its staff because of a budget crisis. As a temporary alternative — to get Walter off the streets—he was put in Patterson House, at 208 East 18th Street, a "halfway house" run by the school for youths returning to their communities from the main center.

Put on Tranquilizers

Dr. Howard A. Weiner, a psychiatrist who was then in charge of Patterson House, remembers Walter was "extremely bright verbally" but says he was "as disturbed as any kid we had."

Like many maladjusted children from the poorest, most disorganized families, he would erupt into towering rages when he felt himself under pressure and he had to be held until he regained control. Usually that took at least an hour, so it was decided to give him 50 milligrams of the tranquilizer Thorazene four times a day.

At first, Walter showed his suspicions about his new surroundings by taking food from the table in a napkin and hiding it under his bed. Gradually, when he discovered that his stockpiles were left alone, he stopped hoarding.

After his wariness subsided, he permitted himself to draw close to his childcare counselor, John Schoonback, a recent graduate of the University of Michigan. Learning that they both had Dutch names, Walter eagerly proclaimed that they were "soul brothers."

'Great Little Kid'

Mr. Schoonbeck, who now is on the staff of Time Magazine, says Walter was "a great little kid". Dr. Weiner credits him with giving Walter the warm, reliable affection he had rarely found in an adult.

Encouraged by his counselor, Walter finally put in an appearance at P.S. 148. In fact, in May he went there regularly — his first stretch of steady school attendance in more than a year and the last in his life.

Flora Boyd, a teacher at the school, says Walter had never learned to read beyond the first grade level but thought he could catch up. "He was an intelligent little boy," she recalls. "Of course, he had a lot of problems. But he could learn."

Finally a place opened for him at Wiltwyck's pastoral upstate campus, and on June 20, Mr. Schoonbeck accompanied him to Yorktown Heights — the fifth separate institutional setting in which he had been lodged in 15 months.

Walter felt that he had been betrayed and trapped. He had never been told that his stay at Patterson House would be temporary. It was a repetition of his experience with Mrs. Banks and, predictably, he flew into a fit of anger on his first afternoon at the school.

Wiltwyck's troubles, meantime, had gone from bad to worse. In May, a third of its staff had been suspended after protesting that students were receiving inadequate clothing and food in the wake of the economy drive. They also charged that there had been instances of brutality.

In the next two months Walter ran away at least four times. As justification, he told his family he had been beaten at the school. Wiltwyck concluded that it could not hold Walter without his mother's cooperation, and that this was unavailable.

Back in Family Court

On October 10, 1968, Wiltwyck turned Walter back to Family Court, which meant he was where he had been more than a year earlier, only more frustrated and "street-wise".

His involvement with institutions was now nearly ended.

It took warrants to bring him and his mother to court so that he could be ordered to go to school, or to Harlem Hospital for psychiatric counseling, or to one of Haryou-Act's "self-help teams". When one order was ig-

nored, the court would simply hand down another.

Asked why the court had not placed him in a state institution — a training school or mental hospital — in order to take him off the street, a judge replied that Walter, who was too disturbed for Wiltwyck, did not seem disturbed enough.

In fact, the probation officer assigned to the case recommended last spring that he be detained in a training school. But Walter's sister Regina insisted that her mother oppose the recommendation in court. In the back of her mind were recollections of the state institutions in which she was placed after she became pregnant at the age of 12.

Question of Survival

She knew that a youth in detention had to "stay by himself" to survive, she said, for there were always homosexual fellow inmates threatening to "mess up his mind." Regina wanted Walter to receive care, but she thought the probation officer only wanted to "criticize him" and "lock him up". In her view, state institutions were no less dangerous than the streets.

The Director of Probation, John A. Wallace, agreed that a state training school probably would not have been an ideal setting for the boy, but as a practical matter, he said, it was the court's last option. The judge, however, honored the mother's objection.

Theoretically, the welfare caseworker assigned to Mrs. Price should have kept tabs on Walter. But welfare caseworkers in Harlem are responsible for 70 to 80 cases, a population of 200 or more. Mrs. Price's caseworker never entered her son's life.

On his own, Walter continued to search out adults he felt he could trust.

In November, he went down to East Sixth Street to call on John Schoonbeck, who had quit Patterson House in discouragement and was packing for a trip to Africa. Walter asked plaintively if he could come along.

Forays With Gang

On the block he had a half-dozen households where he dropped in regularly at unpredictable hours to cadge food, coins, an undemanding hour in front of a television set.

One addict said Walter tagged along after a gang that called itself Bonnie and the Seven Clydes. The gang specialized in auto thefts and shoplifting, and he accompanied it on several forays downtown.

He also teamed up, it was said, with some older youths who conducted raids into Morningside Heights and learned to snatch purses. On at least one occasion he was said to have "taken off" — that is, robbed — a drunk, although Walter never did attain 5 feet in height.

According to Regina, he bought most of his own food and clothes and sometimes had as much as $50 in his pockets. But it is doubtful that he had any regular income as a drug courier, as has been alleged, for he continued until his last days to hustle for small change, selling newspapers and delivering groceries.

In his last month, Walter's already disastrous family situation deteriorated sharply.

Last summer, Mrs. Price was living most of the time on 117th Street, although her younger children were still in the apartment on Eighth Avenue. Walter stayed on the block too, although not with her, sometimes sleeping on a fire escape above a warehouse.

When his mother saw him, she would shout, "Go home!" Walter would shout back, "Go home yourself!"

Sometimes, neighbors say, she would call the police on her son.

Turning to Narcotics

In November, the whole family was evicted from the Eighth Avenue apartment because Mrs. Price had not paid the $73.10 monthly rent for seven months out of her $412 a month welfare check.

She said she was holding the money in escrow because the toilet hadn't worked for a year and a half, but never got to Rent Court to explain this to the judge, perhaps because she no longer had the money.

Tony Vandermeer became distraught when he heard the news and got permission to come down from Yonkers for a day. It was not only the eviction that alarmed him — word had also reached him that Walter had started to take drugs.

The chances are negligible that any child on 117th Street could retain much innocence about narcotics, for the block is wide open to the traffic. Everyone knows the addicts and their pushers and what stairways and landings are best avoided at what times.

Walter's brother Reggie had long been using narcotics. Sometimes he would show his "works" — the eyedropper, needle, cord and bottle cap that are the tools of the addict's vocation — to his younger brothers.

Addict Recalls Him

Interviewed briefly after Walter's death, when he was brought to the funeral home from Rikers Island, Reggie said he knew who had first given drugs to his brother and named a 17 year old addict on 117th Street, who shall be called Theresa here.

When she was visited the next day, Theresa was sitting next to a stove with all its burners on, the only warm corner in an apartment that had been without heat all winter. She readily acknowledged that she had been on drugs for two years, had been close to Walter and had known him to be using them.

Although she denied ever having given him any herself, Theresa said she had often seen him "skin" (inject the drug beneath the surface of his skin) but had never known him to "main" (inject it directly into a vein.) Usually, she said, he skinned at the top of the stairs at 303 West 117th Street or in an apartment next door at 301 shared by two of her fellow addicts.

At 301, the two addicts — call them Mary Lou and Lizzie — also denied ever having sold or given drugs to Walter, but Mary Lou said he would often ask for them. She said that she had seen him "snort" (inhale heroin) and that she had occasionally allowed him to watch while she "mained."

Sometimes she would think of Walter as a "little man," Lizzie said. At other times she would see him as an abandoned child and haul him to the bathroom and scrub him in the tub. Treated like a child, he would behave like one, she said.

The two addicts said they found it hard to imagine his locking himself in the bathroom across the street to "shoot up" by himself.

"Walter was scared of the needle," Lizzie said, laughing indulgently as one might in recalling a baby's first steps. "He'd always say, 'Wait. Don't hurt me. Let me get myself together. Please wait!' "

Brother's Anger Erupts

After the funeral, Tony Vandermeer rushed Lizzie, overturning a floral wreath and shouting, "You killed my brother!" He had heard stories on the block that Lizzie and Theresa had dragged his brother's body on the morning of December 14 from 301 and across the street to 310, where it was found.

Lizzie acknowledged that she had a loud argument with Walter the night before he died over $9 — the change left from $25 he had given her to buy him some clothes — but insisted she had not seen him after that.

"Tony really didn't know me at all," she said. "He just had nobody else to blame."

Another addict — known here as Sugar — moved off the block as soon as the body was found. Walter had been especially close to him since the summer, it was said, and sometimes called him "Daddy."

A lanky, good-looking youth who now worked at two jobs to keep up with the "Jones's" (his habit) Sugar still returns to the block late at night to make his connections.

The other night at about 12:30 a.m. he came ambling into Mary Lou's apartment on the heels of two pushers — one wearing a leather tunic, with the other one done out in a frilly shirt with lace cuffs like an 18th century gentleman.

After an interlude in a bathroom, Sugar appeared rolling down his sleeve and adjusting his cuff link. Behind his dark glasses his eyelids were drooping. His only response to a question about Walter was a perfunctory expression of "shock" over his death.

"But something had to happen," Sugar drawled sleepily. "He was always hanging around."

Dr. Michael Baden, an assistant medical examiner, who examined the body at the scene, said it looked to him like "a typical overdose case." But he cautioned that his office never classified narcotics overdoses as homicides, suicides or accidents, for medical evidence on this point is invariably moot.

Curiously, chemical tests failed to reveal any trace of heroin in the eydropper found next to Walter in the sink — a hint, by no means conclusive, that it might have been planted.

The autopsy proved that Walter had been using drugs for at least three months — possibly longer — but the absence of any track marks on his arms indicated he had probably yet to become a full-fledged addict.

He had also yet to give up on himself. About a month before he died, Walter received a new pair of shoes from Mrs. Carletha Morrison, one of the women on the block whom he would allow to mother him. He said he would save them for going back to school.

A School Drop-In

According to both Regina and Mrs. Morrison, he seemed to think he could not go to school until his mother took him to court. No one seemed to realize that he was still enrolled at P.S. 148, where he had appeared only three times the previous year.

When the school reminded the Bureau of Attendance of his truancy, it was told to stop sending in reports on the boy because Family Court had his case "under advisement" — a bureaucratic formula that seemed to have no specific application.

Occasionally last fall, Walter would drop into the class of his younger brother "Doe" at P.S. 76 and would be allowed by the teacher to stay. He even asked his brother to teach him reading.

"I gave him my book, and any words he didn't know I told him," said "Doe," who is 11.

He was also looking forward to Christmas. Regina had promised to buy him a pair of expensive alligator shoes and a blue pullover. In addition, she said she would treat him to ice skating in Central Park and a movie downtown, probably "The Ten Commandments."

Everyone noticed a macabre touch in a legend stamped on the cheap "Snoopy" sweatshirt Walter was wearing when he died.

"I wish I could bite somebody," it said. "I need to relieve my inner tensions."

"When I heard that I broke down," Regina said. "That was him. That was the way he felt."

CHAPTER V

THE DRUG ABUSE CONTROL COMMISSION -- A REAPPRAISAL

In 1966, the Legislature and the Governor offered a program to divest the Mental Hygiene Department of primary responsibility for dealing with problems of drug abuse and to establish, as an almost autonomous agency within that Department, the Narcotic Addiction Control Commission. (Because of amendments to the laws affecting N.A.C.C. in 1973, which changed the scope of its authority as well as its name to the Drug Abuse Control Commission, the agency will hereinafter be referred to as D.A.C.C.)

The original purpose of D.A.C.C. was conceptualized as: (1) getting most addicts off the streets; and (2) "curing" their addiction.* Once the State's goal had been redefined as reintegration of rehabilitated addicts into society (How People Overseas Deal With Drugs, Commission Report, Legislative Document No. 11, 1973), the conflict between quarantine and cure became apparent.

The role played by D.A.C.C. has been twofold: (1) to fund local agencies for the purpose of providing treatment and rehabilition to addicts; and (2) to operate facilities for the civil commitment of addicts (and now certain other drug abusers) as well as the diversion of drug abusers from the community and

*See "Acquisition & Construction of Drug Abuse Treatment Facilities," Program Audit, Legislative Commission on Expenditure Review, January 18, 1974.

standard criminal justice and correctional systems into D.A.C.C. facilities.

In terms of its own treatment program, a total of twenty-five facilities were acquired by D.A.C.C. or constructed by the Facilities Development Corporation at a total cost of $124.9 million by April 1, 1973. Of these, twenty-three were for treatment, rehabilitation, or aftercare purposes and two provided supportive services. Seven treatment facilities were closed as a result of program changes and budget cutbacks in 1971, leaving eighteen of the original facilities still in the program.

Twenty-five of the total number of construction projects were renovations and only seven were new construction, although the new projects constituted approximately forty-two percent of the total construction costs. Despite community antagonisms, D.A.C.C. had enunciated a policy of attempting to locate its centers near the patients to be served. Prior to 1971, more than two-thirds of the treatment capacity was located in the New York City metropolitan area, and after 1971, nearly eighty-five percent of the programs were located in New York City. Community opposition had resulted in the location of certain programs in commercial areas. For example, one D.A.C.C. facility for women, visited by our own Commission staff, is located at the far western end of forty-first street, across from the now defunct West Side Airlines Terminal Building. Westchester, Nassau and Suffolk were often cited as examples of areas in which multi-modality aftercare centers were missing, although an excellent center for patients was estab-

lished in the highly drug-abuse prone area of the Southeast Bronx.

The building program began with an estimated D.A.C.C. intake of approximately seven thousand five hundred heroin addicts. Actual intake for the first fiscal year was three thousand six hundred forty-five. Nevertheless, a shortage of slots occurred, which forced the closing of intake for six months for nearly half of all those eligible. Between 1968, when intake was reopened, and 1971, D.A.C.C. was able to meet its statutory obligations to accept heroin addicts. Unfortunately, its success rate was not what had been promised, because of the speed with which the program had to be implemented and the requirement of a non-selective admissions policy.

D.A.C.C.'s operating budget request was cut by one-fourth in 1971, as part of a total economy drive, but also with a view toward reorganizing its operation.

Once again, D.A.C.C. closed its intake until changes were made, phasing out seven of the twenty-three treatment facilities (mostly outside of New York City), canceling all contract facilities, and converting most of its remaining residential centers to include outpatient services. As a result of the changes, bed capacity dropped by about one-half, but outpatient capacity slightly more than doubled. The total rated capacity increased by approximately two thousand to a total of some thirteen thousand seven hundred. The total utilization of D.A.C.C. facilities remained at a reported seventy percent. This figure has remained fairly stable, even at times dipping way below seventy percent at certain facilities, despite the increased drug penalties effective

September 1, 1973, although it is difficult to assess the deterrent effect of the penalty structure on heroin abuse.

When Governor Rockefeller issued his pronouncement in January of 1973 that "We have achieved very little permanent rehabilitation -- and have found no cure", many observers suggested that he was reflecting the situation of the Drug Abuse Control Commission, and even at that, only D.A.C.C.'s role as a primary provider of treatment services, rather than its more important role as a funding agency.

The picture presented to the Governor by D.A.C.C. as a treatment agency, was as follows:

1. Over seven thousand of the twenty four thousand persons committed to its care had absconded without a trace.

2. Civil commitments, apart from diversions from the criminal justice system, which were high at the outset, had diminished.*

3. D.A.C.C.'s success rate was not what had been promised, for reasons previously discussed.

4. D.A.C.C. was often unable to house thousands of addicts who might have been eligible for treatment. This

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*See Fourteenth Annual Report of the Temporary State Commission of Investigation, Legislative Document No. 92, April 1972, pp. 268-282 passim.

problem resulted in disillusionment with many aspects of the state's drug program.

ACCOUNTABILITY

Despite the fact that many problems have developed in D.A.C.C.'s operation, since 1967, there has never been a full accounting of and justification for D.A.C.C.'s operating expenditures. This is true despite the partial audit of capital construction expenditures in 1973 and despite the fact that beyond its current state appropriations, amounting to over one hundred million dollars per year, D.A.C.C. has been named, by law, as the designated state disbursment agency for additional millions of dollars of federal funds.

In 1974, the Legislative Commission on Expenditure Review performed an audit on D.A.C.C.'s capital expenditures. Although the audit made no explicit recommendations, taken as a whole, the report implied, with accompanying specific reasoning and case studies, that D.A.C.C. would be wise to end its construction and renovation projects, and to turn over any unfulfilled treatment responsibilities to funded agencies. The auditors also reported that of thirty-one million dollars in federal aid received by D.A.C.C. and forwarded to the Facilities Development Corporation, between 1969 and 1972, all but six million dollars benefitted the Department of Mental Hygiene, rather than D.A.C.C. Another point raised, incidentally, by the audit was why D.A.C.C.,

like other providers of treatment, has been unwilling even to permit its patients to repay some of the cost of their care.*

This latter point has been unintentionally emphasized by a recent progress report of D.A.C.C. which stated that of five thousand D.A.C.C. aftercare patients who responded to questionnaires, at least half are gainfully employed. Of those employed, almost ninety percent were said to be working more than thirty hours per week, while the remainder work part time. At a mean weekly net salary of $106.49, their projected annual net earnings are almost fourteen million dollars.

Commenting upon the partial legislative audit, the Chairman of D.A.C.C. said:

> Generally viewed... the report fails to provide a comprehensive overview of the complex factors involved in D.A.C.C.'s changes and to clarify what has actually occurred since 1966.

We deem it appropriate to juxtapose a recommendation published by New York State's Comptroller, Hon. Arthur Levitt, in his Annual Report for 1974:

> There is a need for government self-evaluation of the effectiveness of its programs. As one writer recently said "... to do better, we must have a way of distinguishing better from worse". Government must ask itself: What programs are working? What programs are weak and how can they be improved? What programs are ineffective and should be discontinued?
>
> As the range and nature of government activities continue to expand in an environment of competition for scarce tax dollars, there is an increasing need for information on the effectiveness of governmental operations. The determinations may be based upon the establishment of qualitative and quantitative standards

* D.A.C.C. officials continue to insist that the cost of accounting for such payments would be greater than the payments, themselves.

> and the operation of systems which measure the attainment of these standards. The absence of such standards and systems can be ascribed, in part, to the difficulty of defining the standards and designing the appropriate measures. Just as there is no universal standard which can be applied to all operations, there is no single measure which can be used to readily gauge effectiveness.

We believe that the statements of both the Comptroller and D.A.C.C.'s Chairman can be reconciled only by a comprehensive audit of the Drug Abuse Control Commission, both as a provider of treatment services and as funding agency for other treatment programs, as an initial step in the overdue evaluation of what the state has received in return for the more than six hundred million dollars already spent by D.A.C.C. We recommend that the Comptroller perform a financial audit of D.A.C.C.

In terms of qualitative assessments of the impact of legislation relating to D.A.C.C. functions, the Temporary State Commission to Evaluate the Drug Laws has already issued a report on drug abuse prevention (cited above), which recommended the redirection of a substantial portion of the twenty-three million dollars, customarily appropriated on an annual basis for such purpose, into school health programs and the detection and remediation of impediments to individual scholastic achievement. It is hoped that further analysis of problems relating to the treatment of drug abusers contained in this report may contribute to an improvement in the quality of such services. However,

systematic evaluation of particular funded programs are also necessary.

EVALUATION

Although D.A.C.C. incorporates in its budget over two million dollars annually for research and testing, it has apparently not undertaken contracts with independent evaluations experts to determine the cost-effectiveness of its own management, nor of the disbursement of state and federal monies, nor of the operations of funded agencies. Moreover, individual local conduits of assistance such as the Erie County Department of Mental Health, report that D.A.C.C. has consistently opposed the funding of evaluative units or evaluation contracts by the providers of treatment services, themselves. Similarly, a spokesman for the Onondaga County Mental Health Department reported, at our Syracuse Hearing on September 25, 1974, that there has been a substitution of genuine evaluation criteria with onerous and sometimes irrelevant compliance requirements. "We end up counting bedpans and the number of beds instead of healthy people". He continued:

> I am saying that given the guidelines and regulations, many of the agencies, and indeed, the County Department, are forced into managing against controls, rather than against goals. I think that one of our discouraging aspects, as we have looked over the guidelines and the legislation, has been an increase in... the compliance criteria, and reporting criteria, and so on, and seemingly an almost absolute lack of attention to evaluative criteria, and what constitutes rehabilitation and success.

The Director of the Alcoholism Research Institute in Buffalo commented on the subject of evaluation, at the time of our visit there. He pointed out that D.A.C.C. keeps asking for more and more information, in greater and greater detail, without nearly the capacity for assimilating such data, and absent the slightest concept of how such information can be validly applied to program improvement. Aside from questions of motivation, there appear to be two reasons for this: the elusiveness of a definition of evaluation and the paradoxical separation of research and treatment funding sources.

In the narrowest sense (only), supervision of compliance with regulations and contract commitments is a form of evaluation. At the very least, the taxpayer is entitled to know whether a psychiatrist or a nurse paid regularly with public funds performs the services promised as consideration for such payment. In this context, the suggested program audit by the State Comptroller would be extremely useful. Beyond compliance, there are other concepts of evaluation which may be employed. One form of evaluation would contemplate judgments regarding the effectiveness of an individual program, from the standpoint of that program's own desire to improve its performance. Many of the programs we visited said that they were too overburdened to make provision for healthy self-assessment, and were not in a financial position to call upon others to help them do so. Another form of evaluation would examine and judge whether, and to what extent, a particular program had been successful in alleviating the per-

sonal and social problem of drug abuse among its actual and potential client populations, and, if a measure of success could be ascertained, how such success might compare with that of other programs, and to what extent variations of the basic approach might be more effective. A third approach to evaluation is the selection of specific geographic areas, (or the state, as a whole, broken down into such areas), the determination of the nature and the extent of the problem in those areas, an assessment of the means available to deal with the problem, and, to the extent of reason, logic, and available program content evaluation, the recommendation of changes to deal with the problem in a better way. This last form of evaluation is necessarily long-term and would require from between three and five years.

The question remains, however, by what criteria should evaluation proceed? The formulation of issues, in a political context, has in the past, led to judgmental standards (putative evaluation criteria) that are meaningless. As the Commission on Expenditure Review and our own Commission have pointed out, once it is acknowledged that addicts and drug abusers are more likely to be successfully rehabilitated if there is interaction between them and community-based training programs or other sources of employment, it is inadequate to continue to insist that all addicts be "taken off the streets". Once it is acknowledged that an addict who is truly rehabilitated and functioning may nevertheless require periodic administrations of methadone, it becomes equally inappropriate to speak of his failure to achieve "a cure", in the

drug-free sense of that word. The risks attendant upon a failure to reduce political issues to their manageable intellectual components, include governmental frustration and demoralization, as well as waste and inefficiency.

To cite an analogy, the problem of space travel was, for years, too big to solve. Only when the term space travel was further analyzed as a series of problems of fuel, thrust and lift-off, and these problems were further reduced to the needs attendant upon the activity of hydrocarbons at a given temperature and pressure, could the problem of space travel be approached. The first step in bringing such scientific thinking to social problems is a similar willingness to seek clues to specialized needs.

Acting in terms of crises has often resulted in hasty judgments and equally hasty refutations of earlier hasty judgments. The drug problem has been with us since the Civil War. The alcohol problem has been with us since colonial days. These problems may continue to be with us for many years more. To suggest that we undertake new beginnings is not to suggest that everything in the past be cancelled out. It is merely to suggest that we try to get our thinking straight on certain aspects of the problem.

Two of the basic intellectual tools for initiating the process of developing evaluative criteria are the ideas of risks and opportunities. The questions which serve as the foundation for an evaluation of the drug problem and how to treat it are:

Risks:

¶ What are the risks one must accept -- the risks built into the nature of any approach to treatment?

¶ What is the risk one can afford to take?

¶ What is the risk one cannot afford to take?

¶ What is the risk one cannot afford not to take?

Opportunities:

¶ How can one focus on maximizing opportunities, rather than on minimizing risks?

¶ How can all major opportunities be scrutinized jointly, systematically, and in respect to their characteristics, rather than one by one and in isolation?

¶ How can one determine which opportunities and risks fit the area of treatment, and which are not appropriate?

¶ How can one strike a balance between the immediate and easy opportunities for improvement and the long-range and difficult opportunities for innovation and for changing the character of the problem?

These are the fundamental questions into which most of the commonly stated issues relating to drug abuse treatment can

be reduced. A careful reading of our report, Employing the Rehabilitated Addict (cited above) will demonstrate a practical application of the risks-versus-opportunities analysis. Beyond these questions, however, one must take cognizance of the fact that most public institutions are over-administered, but not administered for:

1. A "thought-through" answer as to "what is our business, and what should it be?"
2. Clear objectives and goals with emphasis on the relationship between results and those objectives and goals, as well as control of costs.
3. Definition of priorities as minimal acceptable results. Deadlines for the results. Making someone accountable for the results.
4. Definition of measurement of performance.
5. Building self-control from results into the system.
6. Organized audit of objectives and results and establishing a mechanism for sloughing off obsolete or unproductive activities.*

We believe that evaluation of drug treatment programs

*Drucker (1973), as quoted in New York State Task Force on Alcohol Problems Position Paper, September, 1974.

should be carried on at all three levels: individual programs, comparisons among programs, and an analysis of the State's needs and its present capacity to meet those needs.* We recommend that top research priority be afforded to these questions.

ORGANIZATION

We have suggested methodical evaluation, neither as a slogan, since we have offered a preliminary outline for actual inquiries, nor as a pretext for inaction, since we are also mindful of problems which exist in the funding and delivery of treatment services, and which should be addressed at this time. Foremost among these problems is the faulty relationship among services to drug addicts, drug abusers, alcoholics and, inferentially, persons with emotional problems. An analysis of this problem has been prepared by the Director of the Division of Addiction Services of the Erie County Department of Mental Health.

In Erie County, as in most of New York, alcohol is viewed as the primary drug of abuse. This view is voiced most strongly by those involved in the delivery of drug abuse services; services which traditionally have excluded alcoholism as a problem central to their concerns. This view upon the part of providers of drug abuse services stems from their experiences in dealing with the very pragmatic problems associated with attempt-

*Such analysis to be coordinated with present research studies on the problem of alcoholism.

ing to provide effective treatment and rehabilitation services to their clients. They have found, for example, that a very large percentage of youth who have a primary symptom of abuse of drugs also have a parent who is an alcoholic. In attempting to treat the client and his family they, of course, must attempt to deal with the parent's drinking problem. They have found that the vast majority of youthful drug abusers do not have a primary symptom of a singular drug of abuse but instead, present a pattern of multiple drug-alcohol abuse. In attempting to treat these clients they must, of course, deal with their drinking problems. They have found that methadone maintenance clients, while on methadone as well as after withdrawal from methadone, may develop serious drinking problems. Again, in order to continue to treat these clients, they must treat their drinking problems.

From the perspective of the provider of alcoholism services the pattern of multiple substance abuse is quite similar. For example, the alcoholic housewife not only abuses alcohol but often abuses other drugs such as barbiturates. In order to treat such a client her drug problem must also be addressed. The alcoholic blue collar worker, in addition to abusing alcohol, is often found to be abusing tranquilizers and amphetamines. Again, the drug abuse problem must also be treated.

Mental health professionals have historically viewed the alcoholic and the drug abuser as two distinct client groups with different constellations of psychodynamic conflicts and problems, and, therefore, as groups which require separate and unique

treatment regimes. This early view still represents the opinion of a large segment of the mental health professional community. It is at least in part responsible for the separate bureaucratic structures which have been established at the Federal and State levels to fund drug and alcohol programs and which have proliferated separate and distinct alcohol and drug abuse treatment programs throughout the State.

A view which is shared by an increasing number of mental health professionals is that alcohol and drug abuse can be conceptualized as two partially overlapping halves of a single dimension, with the public inebriate and the heroin addict holding positions at the opposite ends of this single dimension. The implications of this conceptual view are: (1) that certain subgroups within the alcoholic and drug abusing population are dissimilar in their characteristic problems to the extent that they can best be treated in separate programs utilizing unique modes of intervention for each group; and (2) that the vast majority of the alcohol and the drug abusing population are similar to the extent that they can be viewed as a larger group of substance abusers whose problems can be addressed within a single treatment program. As an analogy, one does not establish two separate outpatient psychiatric clinics: one to provide treatment services only to phobic patients and the other to provide treatment to neurotically depressed clients.* This latter view does not negate the necessity to see each client as unique in his own right and the related need to tailor a treatment approach specifically de-

*This is not to say that alcoholics and drug addicts are ordinarily mixed in the same clinic setting.

signed to address his or her specific problems. Simply, the implications here are that the treatment skills and services needed to address these overlapping populations can most efficiently and effectively be delivered from a single program base.

Unfortunately, the obstacle to a truly integrated approach to addiction treatment programming is the requirement that the utilization of State Aid must be justified on the basis of services to either the the drug or alcohol abusing client population. The Director of the Nassau County Drug and Alcohol Addiction Commission sought to underscore this point:

> The State of New York ... still separates drug and alcohol programs and funds. Federal, County, and Town governments all have seen polydrug use as requiring coordinated services.
>
> Unchanged...is the problem of furnishing services to the polydrug user where alcohol is the primary drug, because the legalities of reimbursement are still a step behind the need.
>
> If someone comes to us with a mixed addiction and barbiturates can be called the primary drug, we and our subcontract agencies will be reimbursed by the D.A.C.C. even if alcohol is a secondary drug. However, if the patient's primary usage is of alcohol combined with other drugs, we have two options: We can turn the patient away -- which would be unthinkable -- or we can accept him or her and prepare to face the consequences of non-reimbursement. In either case, as you can see, we are in an untenable position.

That untenable position has led staff personnel to be unsure of whether to accept persons needing help into their programs, and "unthinkable" or not, we have received reports that persons have been denied assistance because they turned to an

alcoholism program and were also drug abusers, or they turned to a drug program, but their problem was viewed primarily as one of alcohol.

D.A.C.C., itself, appears to have begun to understand some of the ramifications of this paradox. As a provider of treatment services, D.A.C.C. has begun to encourage an approach to treating families of addicts on a voluntary basis. However, in a written submission to the Commission, dated November 21, 1974, D.A.C.C.'s Chairman stated:

> Increasingly, D.A.C.C.'s approach entails reaching individuals not previously involved [in treatment] -- such as voluntary persons and their families involved around drugs. Thus, siblings as well as parents with various kinds of drug problems (except for primary alcoholism), can be treated by D.A.C.C. on a voluntary basis (emphasis added).

The typical youngster in need of help today, whatever the ongoing symptom, is usually characterized by the jargon of the helping professions as manifesting an "unsocialized aggressive reaction of adolescence". Family Court and drug program spokespersons throughout the State have estimated that as many as eighty percent of the children in trouble they see have at least one parent who is an alcoholic or a drug abuser. We believe that it tends to place extraordinary pressure on a family unit to attempt a treatment plan for a family which envisages a drug treatment program for the barbiturate - using teen-ager, A.A. for his mother, a mental hygiene alcoholism program for his father, a mental hygiene clinic for his wayward sister, and as

many scattered physicians to treat gross medical complaints as there are gross medical complaints. On the other hand, unless a treatment facility consists of staff members who are competent to deal with the individual problems of various clients, there may be undesirable results from referring several family members to a program realistically equipped to handle the problems of only one of them.

Two general remedies have been proposed to lift the State out of this organizational quagmire. Erie County, among others, believes that a Division of Addiction Services should be created within the structure of the New York State Department of Mental Hygiene. The new Division would incorporate the present Division of Alcoholism and the Drug Abuse Control Commission, and could plan and administer a unified addiction services program withing the context of a total mental health service delivery system.

A leading Brooklyn treatment program Director expressed horror at this suggestion. She wrote:

> If Mental Hygiene funded drug programs, they would be ineffective, bureaucratic disasters full of social workers who know nothing but non-judgmental traditional therapy. D.A.C.C. is probably the best run funding source. It would be important for them to be open to innovated approaches.

Nassau County, among others, tends to agree with this judgment; however, some of the logic seemed to be based upon the view that while drug abusers may turn to alcohol, classic alcoholics do not usually turn to drug abuse. Even if true, this

particular argument appears to us to be academic, since the client we are talking about presents both symptoms, and which came first is the very irrelevancy we are all seeking to dismiss.

When competition is thrust upon two agencies to perform similar services, and unification of those agencies does not appear to be possible in the near future (except, perhaps, nominally), prudence would dictate that the problem sought to be alleviated should be viewed from the standpoint of the client. While many problems exist in the Department of Mental Hygiene, and while a "social work" bias has been recognized by objective critics of the Division of Alcoholism, the profound need for adequate medical examination and treatment of polydrug-alcohol abusers, and the greater likelihood of the accessibility of such care under the Division of Alcoholism, leads us to view the Department of Mental Hygiene Division of Alcoholism as the appropriate supervisory and financial conduit for polydrug-alcohol abuse treatment. Ample statutory authority already exists for the provision of such services under Article eleven of the Mental Hygiene Law.

RECOMMENDATIONS

We make the following recommendations regarding the Drug Abuse Control Commission:

1. D.A.C.C. has been reexamining its role as a primary provider of treatment. We adopt as a recommendation the view implicit in the January 1974 report of the Legislative Commission on Expenditure Review that while continuing to fund other treatment programs, D.A.C.C. should continue to reexamine the scope of its role as a primary provider of treatment, particularly in light of the fact that there has been no upsurge in commitments to D.A.C.C. as a result of increased drug penalties.

2. We recommend the development of a Drug Research Institute to bring together the work of existing New York State drug research undertakings and to develop them into a comprehensive institute, similar to the Alcohol Research Institute, with which its work should be closely coordinated. We further recommend the Drug Research Institute begin objective evaluations of D.A.C.C. programs and D.A.C.C. funded facilities.

3. We recommend that the State Comptroller perform an audit of the operations of D.A.C.C. and D.A.C.C. funded agencies and facilities.

4. Pending the creation of an agency to deal with all addictions, we recommend that the Department of Mental Hygiene Division of Alcoholism be given expanded authority to treat polydrug abusers with alcohol problems. We believe that D.A.C.C. and the Department of Mental Hygiene Division of Alcoholism should be required to promulgate regulations governing treatment in drug programs of polydrug abusers with alcohol-related problems. For doubtful cases, there should be a joint local referral committee to decide which agency will take responsibility.

CHAPTER VI

DRUNK DRIVING: AN OVERVIEW

A. THE CANADIAN EXPERIENCE

The Canadian Criminal Code applies in all provinces and territories of Canada. Sections 222-224 of the Code govern restrictions on drinking and driving. The Canadian Criminal Law Amendment Act was enacted in June 1969, amending Sections 222-224, and effective across Canada on December 1, 1969. By this Amendment, suspected drinking drivers, who are apprehended, are required, under Section 223, to provide samples of breath by police analysis, and under Section 224, blood alcohol concentration in excess of 0.08% constitutes a punishable offense. Punishment on conviction includes a fine of $50-$1000, or imprisonment for up to six months, or both. Refusal to provide a breath sample without reasonable excuse can result in similar punishment. While license suspension is not mentioned in the Criminal Code, the provincial or territorial government will suspend a convicted driver's license. The average period of suspension is six months.

Prior to December 1, 1969, only those drivers who exhibited obvious physical signs of impairment were apprehended. The Canadian driver was not required to undergo a chemical test to measure his blood alcohol level.

The 1969 Criminal Law Amendment ("The Breathalizer Legislation") enabled the various police forces in Canada to administer chemical testing of suspected drinking drivers on a

national basis and provided, for the first time, a blood alcohol concentration above which it was an offense to be operating a motor vehicle.

The Breath Test

In England, and the United States, breath tests are employed only as a preliminary check for alcohol levels as a basis for further tests (e.g. New York's pre-arrest breath testing statute). In both countries, blood tests are given to suspected drunken drivers because it is felt that this direct method is much more reliable and accurate than the indirect determination by breath analysis. In both countries, only the results of a blood test are admissible in court.

The Canadians, however, believe that the advantages of breath testing outweigh any disadvantages for the following reasons: a) the sample can be obtained in a few minutes; b) breath analysis closely reflects arterial blood levels at the time of the test; c) test facilities are minimal and cost per test is much lower than laboratory analysis; d) breath analysis eliminates problems of identifying the specimen donor, as well as most of the collection, identification, preservation, transportation and other problems common to all body materials; e) breath analysis is more acceptable to the driving public.

Administration of the Breath Test

The Criminal Code requires a driver to take a breath test only when the police officer has "reasonable and probable

grounds" to believe that the person is committing, or has committed, the offense of driving while impaired. This section has been interpreted to mean that the policeman must observe physical evidence of impairment, such as slurred speech, glassy eyes, flushed face or erratic driving, before he can require a breath test.

All tests are carried out at the police station. Before undergoing the test, the driver must remain under observation for fifteen minutes. During this period, the breathalizer operator interviews the driver. Various sobriety tests are given, including walking a straight line, putting one's finger to one's nose, and picking up coins from the floor.

A breath sample is then given for analysis. After a few minutes, the test is repeated to insure the accuracy of the first reading. The operator then fills out an affidavit with details of the date, time, location and results of the test.

If a driver is charged with driving with a blood level of alcohol exceeding 0.08%, he is usually released on bail with police approval. If he is obviously intoxicated, he is detained at the police station until someone comes for him.

Evaluating the Breathalizer Legislation

How effective has the Breathalizer Legislation been in decreasing serious road accidents involving alcohol? In its 1974 report,* the Canadian Ministry of Transport concluded that the legislation did not have a large or sustained effect, and

*Carr, B.R. et al, The Breathalizer Legislation: An Inferential Evaluation, Ministry of Transport, Canada, 1974.

further action programs will be required. Some of the observations were:

1. A slight decrease in fatal accidents for 1970, but in 1971 road fatalities returned to 1969 levels, and 1972 figures were five per cent higher.

2. There is no compelling evidence that alcohol has played a lesser role in fatal accidents since the Breathalizer Legislation.

3. The legislation has caused an increase in the number of drinking/driver charges. However, the legislation has not affected the likelihood that a driver with a high BAC* (above 0.20%) will be charged. Rather, the risk has increased for those drivers above 0.10% and below 0.20%.

A comparison of statistics of three provinces casts heavy doubts upon the effectiveness of the Breathalizer Law. In 1969, 702 dead drivers were tested for alcohol in Alberta, Ontario and New Brunswick. Of these, 385 or 54.8% had alcohol in their blood and of those with alcohol, 322 or 83.6% had higher-than-legal levels of blood alcohol.

By 1972, the number tested had jumped to 1,044, with 588 or 56.5% found to have alcohol in their blood. About 82% of these had higher than 0.08% blood alcohol.

On the other hand, the Breathalizer Law did have a significant impact upon police action. Across the country, the number of impaired driving charges has increased dramatically,

*BAC is the common abbreviation for Blood-Alcohol Content.

and the conviction rate of those who are tested is very high (96%).

Rehabilitative Programs

Two of Canada's less populated provinces, Alberta and Saskatchewan, have recently begun reeducation programs for convicted impaired drivers.

The Alberta program is set up as follows:

Convicted drivers in Alberta are ordered by a Provincial Judge to attend the A.I.D.P. (Alberta Impaired Driver's Program) of four lectures as a condition of probation. The Probation Department is responsible for monitoring each student through the successful completion of the project. Participation in the program has no effect upon a revoked or suspended license.

Lectures are held in the evenings in the traffic court. Each session is approximately two hours long. At the first lecture, students are told the purpose of the project. "This Course is not intended to stop you from drinking. This is a decision only you can make. However, the Course is very much concerned with the harmful combination of driving and drinking. The Course is conducted to encourage each of you to examine and assess your own behavior while you drive and the reasons why you are here, and so to be in a better position to choose between driving while impaired or only when sober. We believe that you have an interest in the ability to correct and modify your behavior - once you know the facts."

Initially, students are asked to fill out a "Personal Questionnaire" and a "History of Events Leading to the Impaired

Arrest". These forms will later be assessed by the program (to determine if a follow-up is indicated) and will be used for statistical purposes.

Students are lectured on a variety of subjects by various officials. In the first lecture, a police officer speaks on the obligation of the police, and a representative of the prosecutor discusses Federal and Provincial legislation on impaired driving. License suspension and reinstatement, and automobile insurance are the topics of the second lecture. During the third lecture, a representative of the Alberta Alcoholism and Drug Abuse Commission (AADAC) discusses the progressive phases of alcoholism. Also covered the third week are driver training and safety and available resources for guidance and help. The last lecture includes a talk on the terms of a probation order by a probation officer and comments by a judge.

A committee consisting of the Chairman of the Driver Review Board (which reinstates licenses), a supervisory Probation Officer, a Court Counselor and a Supervisor of Treatment of the AADAC determine: a) those students who have drinking problems and b) those who have repetitive driving infractions, as well. In the case of the problem drinker, a referral is made to the Out-Patient Clinic of AADAC. The problem driver is referred to the Traffic Clinic of the Alberta Safety Council.*

The effectiveness of this program has not been measured at this time. The program's directors are cautiously

*Strachan, J., A Working Policy and Procedure Manual on the Alberta-Impaired Driver's Program, Department of Highways and Transport, Government of Alberta, 1973.

optimistic that some positive changes may be forthcoming.*

Provincial Legislation

Legislation in the Canadian provinces supplements the Federal Criminal Code. In general, the individual provinces have the authority to formulate their own standards for apprehending the drunken driver, and as mentioned above, they have complete authority over the suspension and reinstatement of licenses after conviction.

The Vehicle Codes of British Columbia and Saskatchewan provide for on-the-spot roadside checking of suspected impaired drivers. Where a police officer has reasonable grounds to suspect a driver has consumed alcohol, he may request the driver to surrender his driver's license, which is thereby suspended for twenty-four hours. The driver may request, at the scene, a breath test and if the test shows a BAC of less than 0.08%, his license is returned immediately. If the reading exceeds 0.08%, the license remains suspended for the twenty-four hour period and no charges are laid.**

In 1969, over twelve thousand licenses were suspended in this manner in British Columbia alone.

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*Brown, P. et al, Evaluating the Effectiveness of Reeducation Programs for Convicted Impaired Drivers, paper presented at Sixth International Conference on Alcohol, Drugs and Traffic Safety, Toronto, Canada, 1974.

**This procedure does not apply where a police officer intends to proceed under the provision of the Criminal Code.

British Columbia has begun a pilot program where, following a second suspension for impaired driving, the offender must obtain treatment from a medical clinic or other such agency, and certificiation of improvement in controlling the use of alcohol must be received by the Superintendent of Motor Venicles before reinstatement of the driving privilege.

British Columbia, Manitoba and Ontario have laws which protect the medical profession in reporting medically high risk drivers to the authorities. Doctors, however, are under no duty to serve such notice to the licensing agency.

Legislation After 1969

The Criminal Code was amended again in 1972 to provide for limited licenses to convicted drivers who have had their licenses suspended. Apparently, this change has had little success since Canadian safety experts are predicting its repeal during the next session of Parliament.

Proposals for Future Action

In a recent report*, the Canadian Ministry of Transport determined that there are no simple solutions to the drinking driver problem. Since they were also confronted with the fact that solid information is lacking on the direct and indirect or delayed effects of countermeasures implemented in the past, it was felt that any recommendations made in the report were to be of an experimental, explorative and research-oriented nature. However, the report did emphatically reject the punitive approach (long jail sentences, harsh fines, long periods of license suspension).

*Alcohol and Highway Safety: A Review in Quest of Remedies, Ministry of Transport, Canada, 1973.

The proposals are:

1. Set BAC limits rather high, otherwise the police and the judicial process will not charge and convict offenders.

2. Increase the subjective apprehension risk of the driver. The driving public seems to be most responsive to this subjective estimater of the risks of being apprehended. Consequently, there must be a maximum police presence on the highways.

3. Improve the legal process. The total process of apprehension-prosecution-conviction should be designed to facilitate learning and behavior change on the part of the public. Since quick justice is effective justice, it is necessary to expedite the legal process, utilizing such procedures as short-term roadside license suspension and other measures that provide immediate punishment after the act.

4. Fines, if imposed, should be in proportion to the offender's income and all fines should be made payable in installments in order to protract the learning experience of the individual.

5. Punish accessories to the offense. The law should be formulated and executed in such a way that it not only deals effectively with regards to offenders as individuals, but actually impinges upon the social interaction patterns in which drinking followed by driving takes place. This may be achieved by much wider use of the concept of co-responsibility of those who serve drinks, ride as passengers, but who do not make an active attempt to prevent the offender from driving. The existence of this rule should be widely publicized.

6. Establish special traffic courts. If judges and court personnel were better informed of the ramification of the role of alcohol in road safety, if they had more interest in the cases they see, kept abreast of research findings in the area, and instigated novel approaches, greater effectiveness can be expected.

7. Expand research efforts. At this time there is no empirically verified proof of the effectiveness of countermeasures that are in existence.

8. Educate the public on the real risks of drinking and driving. Mass communication campaigns should be conducted. Warning labels should be placed on alcoholic beverages. Bars and restaurants should post warnings concerning driving after drinking. Driver training courses and driver examinations should include a discussion of alcohol and traffic safety.

9. News media should report accidents more frequently and in a way to maximize the opportunities for learning. A person might learn from the road collisions of others if the relevant information of contributing factors is made available.

10. Reward desirable driving behavior, such as discounts in insurance premiums. Punishment has a minimal and temporary effect upon behavior but the rewarding of desirable behavior produces consistent and long-term changes.

A very recent report by the Province of Ontario* has set out the scope and characteristics of the drinking driver

*Report of Government of Ontario Interministerial Committee on Drinking and Driving, September, 1974.

problem in Ontario, and outlines the steps that will have to be considered in trying to reverse failures of the past.

Outlining a blueprint for intervention, the report recommends activity at three distinct stages -- primary, secondary and tertiary:

Programs of primary intervention (before the drinking and driving occurs) could best be initiated via educational media programs, classroom instruction, provision of alternative means of transportation, mechanical intervention (a device preventing an impaired driver from being able to start his car), increased public obedience to drinking driving laws, awareness of the costs of drinking-driving and increased probability of detection.

Programs of secondary prevention would involve giving a higher priority to detection of drinking drivers and increasing enforcement manpower at specific times and places. It might include establishment of special patrols, trained and equipped for the task, working under publicity.

The program of tertiary intervention (implemented after the driver has been detected and convicted but before he recommits the offense) would revolve about the use of penalties and the rehabilitative role of the court.

The Sixth International Conference on Alcohol, Drugs and Traffic Safety

Canada was the host country for the Sixth International Conference on Alcohol, Drugs and Traffic Safety held in Toronto in early September, 1974. During the conference, several Canadian researchers and traffic safety officials addressed themselves to the magnitude of the drinking driver problem in Canada, and the

ways in which the alarming trend in alcohol-related death and accidents could be abated.

Brian Carr, an official of the federal Ministry of Transport, said that the Breathalizer Legislation has been a failure because the public does not believe the chances of detection are high. To remedy this situation, Carr believes that the police should be given the authority to test a person's breath upon only a mere suspicion by the police officer of alcohol consumption. (Present law requires an officer to have reasonable grounds that an offense has been committed.) The introduction of road screening devices and the implementation of widely advertised spotchecks, Carr feels, would greatly increase the fear of apprehension for potential drinking drivers.

John Hoday, an inspector with the Royal Canadian Mounted Police, concurred with Mr. Carr's recommendations. Present law, which requires "reasonable and probable grounds" and not merely some evidence of drinking before a test can be ordered, results in the police not detecting the driver with a relatively low but illegal BAC (from 0.08% to 0.15%).*

Mr. G.J.S. Wilde, a psychologist, university professor and one of Canada's leading researchers on drinking/driving, stated in his presentation that legislation aimed at apprehending impaired drivers, penalties imposed on those who are caught and mass public education campaigns have all been virtually fruitless in getting the drunk driver off the road in Canada. Mr. Wilde, a

*The average BAC of tested drivers in Canada is 0.17%.

behaviorist, indicated that instead of the present legal approach, the law should be designed to address itself more "to the very patterns of human interaction, in which drinking takes place." (Expanding the concept such as accessory to the act and co-responsibility of others.)

B. THE EUROPEAN EXPERIENCE - A PARTIAL VIEW

England

For more than a quarter of a century following the development of the automobile, there was no law governing drinking and driving in England. Under the Licensing Act of 1872, a penalty was applied to being "drunk in charge" of horses and steam engines - the major means of transportation before the auotomobile. It was not until the 1930's that the penalty was extended to motor vehicles. The Road Traffic Act of 1930 made "being under the influence of drink or a drug to such an extent as to be incapable of having proper control of a vehicle" a criminal offense. Subsequent definitions of the illegal behavior became "being unfit to drive through drink or drugs" (Road Traffic Act of 1960) and driving when the "ability to drive properly is for the time being impaired" (Road Traffic Act of 1962).

These changes in the statutory language reflect the fact that experience in charging and convicting drivers was full of difficulties. An accused person was not required to provide specimens for chemical analysis for alcohol, and courts had to rely on

direct evidence such as eyewitness reports and doctors clinical examinations. Convictions, particularly by sympathetic juries, were difficult to obtain, and many drivers were in fact acquitted with blood alcohol-levels higher than 0.15%.

Finally, in 1967 England enacted into law the sweeping Road Safety Act which introduced a maximum prescribed level of blood alcohol for drinking/driving. The level chosen was 0.08% and was based on experiences of other countries and the advice of the British Medical Association. The Act authorized police to give pre-arrest, on-the-scene, breath tests under certain conditions.* If a driver failed the roadside test, he was to be taken to a police station for a blood-test, on the basis of which a charge would or would not be made. Violation of the law carried a mandatory punishment of a one-year license suspension and a fine of up to one hundred pounds, or imprisonment for up to four months, or both.** Similar penalties were also established for failure to submit to any of the tests for BAC level.

During the interval between the passage of the legislation and its effective date, the British Government engaged in a massive publicity effort to inform the public of its obligation under the new law. The results of a public opinion survey in early 1968 indicated that most people knew about the new laws

*If the driver is involved in an accident, or the policeman has "reasonable cause" to suspect the driver of having alcohol in his body or of having committed a traffic offense while the vehicle was in motion.

**The Act did not increase the penalties for drinking and driving. Jail sentences are rarely imposed. Fines average twenty to forty pounds.

and penalties and understood that they were subject to breath tests.

The British Government claimed that dramatic decreases occurred in the traffic casualty rate as a result of the legislation. In the first full year (1968), deaths were seventeen percent fewer and all casualties eleven percent fewer than expected from the trend over the previous four years. While positive effects were noticeable through 1970, after three years the dramatic reductions began to return to former levels.

In a recently published article,* Professor H. L. Ross has undertaken an evaluation of the Road Safety Act of 1967. He surmised that the key to the initial success of the Act was the increased drivers' expectations of punishment if they were to drink and drive. However, the ambivalent and moderate attitude of the legal system, particularly the police, in applying the legislation, rendered these expectations baseless so that the learning process based on drivers personal experiences reduced the effectiveness of the Act over time.

Sweden

Sweden was the first country, in 1934, to use a statutory maximum permissible blood alcohol concentration, ascertained by a chemical test. The current Swedish law creates two offenses - first and second degree drunkenness while driving, the former defined by a blood alcohol concentration over 0.15% and the latter

*Ross, H.L., Law, Science and Accidents: The British Road Safety Act of 1967, Journal of Legal Studies, January, 1973.

by a concentration over 0.05% where there is other evidence of drunkenness. Either violation results in mandatory license revocation for at least a year, and 73% of drivers convicted of first-degree drunkenness received jail sentences of a month or more.

Swedish insurance companies will not pay claims arising from accidents in which the injured party was the at fault driver who was driving with a revoked license. Swedish law also relieves an insurance company of liability. When a driver is involved in an accident where someone else receives personal injuries or where property damage occurs, should the insured driver be convicted of driving while intoxicated (BAC above 0.15%), the insurance company will pay the claims of the injured party, but the company may then sue the driver for claims paid out.

Police are authorized to stop a motor vehicle at random and administer a breath test to the driver. Roadblocks are often used. The Swedes claim that their laws serve as an effective deterrent to drinking and driving. The Government reports that less than 10% of the fatal accidents are alcohol related. (In the United States, approximately fifty percent of fatal crashes are alcohol related.)

United States traffic safety experts and researchers, however, are highly skeptical of the success claims made on behalf of hard line procedures because of the lack of data and scientific research provided by the government.

C. THE UNITED STATES

Drinking and driving is a major social problem in the United States. The National Safety Council has estimated that the use of alcohol by drivers and pedestrians leads to 25,000 deaths and a total of at least 800,000 crashes each year.

The problem was first identified in 1904, and was first shown to be serious in 1924. Since that time, deterrence of the drunken driver has been a goal of national importance. However, the continual rise in the number of deaths attributable to drunken driving suggests that current sanctions for the offense of driving under the influence of alcohol are not achieving wide scale deterrence. One reason for the difficulty in structuring an effective sanction may be that Americans are willing to accept some risk implicit in any arbitrary distinction between driving after drinking and drunk driving.

What is the crime?

In the past, alcohol impairment in regard to driving was equated with drunkenness; as long as one did not appear drunk one was considered capable of driving a vehicle safely. In recent years, however, research has proven that a driver can be impaired long before signs of drunkenness appear. This new knowledge is now reflected in the laws of all fifty states.

The majority of states specify 0.10%* as the level at which one is presumed to be under the influence of alcohol. A few

*0.15% was used in most states until 1968.

states, New York included, have recently enacted per se laws, under which it is an offense to drive with a BAC of 0.10% or more without proof of overt signs of impairment or intoxication.

At least four states have two categories of drunk driving offenses. In New York, it is a misdemeanor to drive while intoxicated (DWI); and it is a simple traffic offense to drive when ability is impaired by the use of alcohol (DWAI). The presumption level for DWAI in New York is 0.07%.

Implied Consent

This legal principle implies the consent of any person who drives a motor vehicle to submit to a chemical test of his blood, breath or urine for the purpose of determining blood-alcohol levels. The police, however, must have probable cause to believe that the driver has committed an offense before any tests can be administered.

A person may refuse to submit to a chemical test, but in doing so he subjects himself to an administrative suspension of his driver's license. One who refuses is entitled to a hearing to determine if such refusal was or was not "reasonable" under the circumstances.

Some states have laws which specifically permit the fact of a test refusal to be admissible in court. Other states specifically forbid such mention in court. Most state laws, however, are silent on this point.

Pre-Arrest Testing

A relatively new provision which permits "pre-arrest"

breath tests appears in the laws of at least eight states, including New York. Traditionally, a driver could be tested for alcohol only after being placed under arrest. Under this new procedure, a driver may be requested to submit to a breath test any time he is involved in a collision or violation, or the police officer has reason to believe the driver has been drinking. The test is administered at roadside, and if the results indicate that the driver has been drinking to a substantial degree, he is taken to the police station for a more sophisticated test, usually a blood test. New York's law went into effect in 1971.

Penalties

Fines and jail sentences are the penalties for drunken driving meted out by the courts. Although the suspension or revocation of a driver's license is considered by many to be a harsher penalty than the fine or short jail term, that form of sanction is usually administered by the State Motor Vehicle Bureaus, not by the courts. The use of driver licenses for sanctioning purposes will be treated separately.

First Offense

There is a wide variation of penalties. For example, the mandatory minimum fine varies from none at all in Nevada to two hundred dollars in Delaware. New York, Alaska, Maine, Wisconsin and Texas do not specify a minimum fine, but state the fine in terms of "not more than --", one hundred dollars, two hundred dollars or whatever the figure is for that state. Presumably the courts

could impose fines of as little as one dollar and still comply with the law. Tennessee has a minimum fine of ten dollars, five states have fifty dollar minimums, and seven states use one hundred dollars or one hundred fifty dollars as minimum amounts. Maximum fines range from a low of one hundred dollars in South Carolina to one thousand dollars in Alabama and Delaware.

Most of the states prescribe a penalty of either a fine or jail, or both. Arkansas authorizes a fine and a jail sentence. Mississippi and South Carolina provide for a fine or jail, but not both.

Texas, Tennessee and Arizona specify a mandatory minimum jail sentence which cannot be suspended by the judge.

Second Offense

The variety of penalties for the second offense is even greater than for the first offense. Generally, the penalties for the second offense increase, but in three states (Alabama, Alaska and Texas) the punishment is the same as for a first offense. Some states, like Connecticut, do away with a fine for the second offense but specify a mandatory jail sentence. Maximum jail sentences range from three months in Nebraska to two years in New York, Texas and Kansas, and three years in Pennsylvania.

Revocation and Suspension of Licenses

Following conviction, every state provides for revocations or suspensions of varying duration. In some states, including

Nevada, North Carolina and Wisconsin, it is possible to obtain an occupational or limited driver's license to permit the erring driver a minimum amount of driving to prevent undue hardship.

The definition of "suspension" or "revocation" may differ from state to state. In general, however, a suspension extends over a stated period of time, at the end of which the driving privilege is automatically reinstated. A revocation also extends over a stated period of time, at the end of which the licensee must reapply as though he were a new driver, and whether he is granted or refused the license is left up to the discretion of the Commissioner of Motor Vehicles.

Suspension for Driving While Impaired

In the handful of states which have the DWAI category, a license suspension usually follows conviction. In New York, a mandatory two-month suspension is specified. In Michigan, license suspension is not used, but four points are added to driver's record.*

Revocation for DWI - First Offense

This sanction varies from no revocation at all in Wisconsin and Mississippi to revocation for up to one year in several states. In Arkansas, Alabama and Nevada, the license may be revoked. Three states do not specify a minimum period but use "up to six months" or "up to one year." North Carolina and Illinois provide for mandatory revocations but are not specific about the period.

*Points are assessed after conviction of any driving offense. A total of twelve points in an eighteen-month period leads to a suspension.

Revocation for DWI - Second Offense

In some states, the revocation for the second conviction is the same as for the first. All states, with one exception, provide for some mandatory period of revocation, which ranges from a minimum of thirty days in Alabama to a maximum of five years in Massachusetts. Arkansas is alone in allowing a discretionary period of revocation.

Suspension for Refusal to Submit to a Chemical Test

If a suspected driver refuses to submit to a test, it follows that the court will not have evidence of alcohol in the blood. This substantially lessens the likelihood of conviction. As the use of chemical tests became more widespread, the practice of refusing the test also increased. To counteract this practice, the states have enacted "implied consent" laws. These laws are based on the premise that driving on the highway is a privilege granted by the state - a privilege the state may also rescind. Each applicant for a driver's license presumably agrees that, if he is requested to submit to a chemical test by a police officer who has reason to believe that he is impaired or under the influence of alcohol, he will submit to the test. He further acknowledges that if he refuses to submit to the test, his driving privileges will be suspended. Most states have provided for a license suspension penalty for failing to take the test that is as severe, or more severe, than the suspension penalty after the first conviction.*

*Conceivably, a person can have his license suspended after a test refusal and face another suspension if subsequently convicted of DWI.

However, for persons liable for a second conviction, it would be to their advantage in many states to refuse the test and face a less severe penalty. In Delaware, for example, a second offender faces a one year suspension, but only six months after a refusal. Nevada mandates a two year suspension for a second conviction, but only six months after refusal.

Limited Licenses

The practice of issuing limited or occupational licenses is increasing. Almost one-half of the states have a provision for their issuance. Such licenses are usually very restrictive, even to the extent of specifying the hours during which driving may be done, and in what area. All unnecessary or recreational driving is prohibited. In most states such limited licenses can be obtained only after a hearing, at which the need must be justified.

Evaluating the Effectiveness of Legal Sanctions

It had been widely believed that drunk driving behavior could be changed, discouraged, interrupted or prevented through the enactment and application of the punitive laws described above. Although the overall effect of these laws is generally unknown, there are indications that such measures may be of only limited value.

Government officials and highway safety researchers have attempted to explain the reasons for this lack of success. Some of their observations are:

Harsh penalties for driving under the influence, often

cited as a panacea to the DWI problem, can reduce the likelihood of apprehension and conviction by creating a reluctance in police officers, prosecuting attorneys, and judges to act when the penalty appears excessive with regard to the gravity of the offense. (Driver Behavior: Cause and Effect, Washington, D.C.: Insurance Institute for Highway Safety, 1968).

Criminal sanctions are most ineffective in dealing with the most dangerous drivers, the problem drinkers, who constitute the majority of high-risk drinking drivers. (Alcohol Abuse and the Criminal Justice System, Center for Governmental Research, Inc., Rochester, N.Y., 1973).

A frequent criticism of the criminal justice system is that many drivers arrested for drunk driving are permitted to plead to a lesser charge, usually reckless driving. The reasons usually advanced for this practice are: a) drunk driving trials are time-consuming; b) jury trials are frequently demanded; c) prosecutors are aware that juries are often sympathetic to defendants; d) the courts are clogged with drunk-driving cases; e) prosecutors do not feel that drunken driving is a serious charge (unless death or serious injury results). This last reason underscores the fact that many people are ignoring the act that the law prohibits (driving under the influence) and concentrating only on the tragic consequences of that illegal behavior (a highway accident).

Arrest and Apprehension

Presently, the law requires a police officer, before he can stop a driver he suspects of driving while intoxicated, to have

probable cause to believe that the driver has committed an offense (DWI). He does not have the power of his counterpart in England who can arrest a driver upon reasonable cause to believe the driver had been drinking.

The strict laws of arrest have been severely criticized by many traffic safety experts. Often, the arrest or apprehension stage in the enforcement process is cited as the most important reason for our failure to get the drunk driver off the road.

A noted researcher, Professor Robert Borkenstein of Indiana University, has estimated that the average police officer in the U.S. makes an average of two alcohol-related traffic arrests per year. He has found that in a typical community of one million population, with 1,000 police officers, there will be an average of only two thousand arrests and over four million DWI violations.*

The Problem Drinker

The deviant drinker, who constitutes only one to four percent of the drivers on the road, is responsible for more than fifty percent of the serious and fatal alcohol-related accidents. Studies by the Department of Transportation have refuted the general impression that most accidents are caused by the social drinker.

Punitive sanctions for DWI, as currently administered, appear to have little or no deterrent effect on the problem drinker. Consequently, the relatively new

*Remarks delivered at 6th International Conference on Alcohol, Drugs and Traffic Safety, Toronto, Canada, 1974.

"health-legal approach" has been introduced in many areas of the country. This approach views problem drinking as a disorder rather than as a series of criminal acts, and contends that court-referred treatment for drinker-drivers is more likely to effect changes in alcohol-related traffic fatalities than traditional penal sanctions. At this writing most existing treatment programs are "experimental" and only a few states have made statutory provisions for rehabilitation programs. These laws will be examined later in this chapter.

The Federal ASAP Program

In 1969 the Department of Transportation initiated a comprehensive program intended to reduce alcohol-related highway deaths and injuries. The most ambitious component of this program consists of Alcohol Safety Action Projects, "ASAPs," conducted at the community level.

The major goals of ASAPs are threefold.

1. To demonstrate the feasibility and practicality of a systems approach to dealing with the drinking-driving problem, and to demonstrate that this approach can save lives.

2. To evaluate the individual countermeasures within the limits permitted by the simultaneous application of a number of different countermeasures to the same site.

3. To catalyze each state into actions to improve its safety program in the area of alcohol safety.

On-site ASAP activity is said to be composed of four distinct types of countermeasures integrated into a whole by

the local program management. These are: 1) increased law enforcement; 2) stepped-up court pre-sentence investigations to isolate problem drinkers; 3) rehabilitation of problem drinkers and 4) public information and education.

In all, 35 local ASAPs have been started at an average cost of more than two million dollars each, with a total allocation of seventy-eight million dollars.

In the area of enforcement, the major effort is to increase the detection and apprehension of drinking drivers. Each ASAP provides for the establishment of special alcohol enforcement patrols at the times and places where most alcohol-related crashes occur. A second objective is to improve the conviction rate for alcohol-related offenses, through the use of chemical testing equipment, tape recording devices, and video cameras to record the condition and behavior of the arrested driver for use in court. In addition, officers are trained in all aspects of the arrest procedure including the operation of health-testing equipment. At some sites, special mobile breath-testing vans equipped with video tape may be used.

The pre-sentence investigations countermeasure assists the court in making the most individually and societally appropriate adjudication of a drinking and driving offense. An offender is classified as either a problem drinker or a social drinker. Depending on the extent of the individual's alcohol-related problem, a recommendation is made to the court

which may include some type of rehabilitation in addition to, or in place of, a more traditional, punitive sanction.

The investigation varies from site to site, but generally consists of checks of the offender's driving and criminal records, social health agency record, interviews with family members, associates, employers, blood alcohol concentration at the time of arrest, and the use of structured diagnostic interview instruments. In addition, in some cases the investigation includes medical and psychological examinations.

Probation is often used as a tool for referring the convicted offender into rehabilitation programs suited to his needs. The judge, based upon the recommendation growing out of the pre-sentence investigations, places the offender on probation which is conditioned upon successful completion of the prescribed rehabilitation.

The rehabilitation phase of the ASAP program attempts to modify the drinking-driving behavior of those arrested to preclude any further recurrence.* For the social drinker and early problem drinkers, it is intended that exposure to alcohol education will help such individuals recognize the relationship between drinking and drinking-related problems. For the chronic or acute problem drinking drivers it is intended that ASAP-supported rehabilitation will aid such persons in the initial step of the rehabilitation process, a change in attitude. Referral into community-based programs is the next logical step.

*Approximately 40 percent of convicted drivers entered some form of rehabilitation program.

In 1973, the National Highway Traffic Safety Administrations (NHTSA) of the U.S. Department of Transportations published a preliminary evaluation of 29 of the 35 ASAPs in operation. Their conclusions were as follows:

1. The ASAPs have produced a sharp increase in safety activity as indicated by an overall growth of over 150 percent in alcohol-related arrests of the average site during the first two years.

2. ASAPs have been effective in improving the overall safety system as evidenced by the increase in numbers of arrested drivers who are handled effectively by the courts and enter into treatment programs.

3. There has been a small, but statistically significant, reduction in drivers with high BACs using the road.

4. There has been a statistically significant drop in the ratio of nighttime to daytime fatal crashes. There has been a reduction in alcohol-related fatal crashes of between 10 and 19 percent.

This favorable account of the effectiveness of the ASAP program has been challenged in a recent report by the Insurance Institute of Highway Safety.* This study compared year-to-year variations in fatality statistics between groups of areas with ASAPs and comparison groups of areas without ASAPs.

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*Paul Sador, Statistical Evaluation of the Effectiveness of ASAPs, Insurance Institute of Highway Safety, Washington, D.C., 1974.

The NHTSA study was criticized because that report neglected to provide convincing evidence to rule out the possibility of alternative explanations for the positive outcomes in program areas. The favorable results reported by NHSTA could have been part of some regional or national trend not related to ASAPs.

Based upon their statistical analysis, the Institute concluded that "There is no evidence of program effectiveness!"

"DWI -- Counterattack"

In 1966, Phoenix, Arizona initiated a program designed for individuals convicted of driving while intoxicated. While not designed specifically for the problem drinker, this program does educate the convicted DWI regarding drinking problems and their consequences. The four two-and-one-half-hour sessions are devoted to: 1) The drinking driver; 2) alcohol and driving skill; 3) problem driving; and 4) personal action. An united evaluation of this program found a significant reduction in recidivism for those who had taken the course.

The Phoenix program became a model for other "DWI -- Counterattack" programs around the country. The Dade County Driving Under the Influence of Alcohol Countermeasures Program (see Commission report, Drug Abuse Prevention). As was noted in that report, in a sample population of 10,000 students who completed the Dade County course, the recidivism rate was 3 percent compared with a 20 percent rate for a similar population who were not exposed to the course.

Other "DWI-Counterattack" courses have been started around the country. Some, like the program in Westchester County, New York, are sponsored by the Automobile Association of America (AAA).

Rehabilitation

At this writing, at least 9 states* have taken a new approach to the DWI problem by moderating the punishment for convicted drivers while at the same time allowing for some form of rehabilitation.

The principal characteristic of these statutes is the broad discretionary power they vest in the courts in referring defendants to treatment programs. They generally allow referral to a rehabilitation program upon a second, third, or subsequent conviction of DWI. In most of the states the courts are also given the discretionary power to lessen or suspend the jail sentence and fine of the defendant upon his completion of a treatment program. Two states, Vermont and South Dakota relate completion of rehabilitation to the privilege to drive an automobile. This suspension or lessening of the penalty for DWI is obviously an incentive for the defendant to successfully complete the rehabilitation program, because the penalties are generally quite severe on later convictions.

Very little is stated in these statutes as to what actually constitutes a program of alcohol rehabilitation. Generally,

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*California, Iowa, Mississippi, Washington, Oregon, Maine, South Dakota, North Dakota, Vermont.

the court or appropriate state agency is left to determine what an "approved" program is. However, Iowa specifies commitment to a "hospital" or "institution" and the person so committed is considered a "state patient."

Mississippi and Vermont and Maine require referred drivers to pay a fee for their participation in a treatment program.

D. NEW YORK STATE

The Offenses

For over forty years, "driving while intoxicated" (DWI) has been a misdemeanor in New York State. At a time when chemical tests to determine blood-alcohol level were unknown, one had to be obviously drunk to be convicted of DWI. During the 1940s, research in the area of the effects of alcohol upon driving ability proved that one did not have to be severely intoxicated to constitute a menace to himself and others on the highway.* As a result of these findings, New York State in the late 1940s passed a law which permitted the use of chemical tests to determine the blood-alcohol levels of suspected drinking drivers. About the same time another law created statutory presumptions of intoxication based upon blood-alcohol concentrations.

During the past ten years, the Legislature has displayed its concern with the drinking and driving problem by amending the laws time after time. By 1974, except in the area of the rehabilitation of the convicted driver, New York had one of the most detailed and comprehensive statutes in the country. The most important changes have been the addition of two offenses concerning drinking and driving. The first is the *per se* law, under which it is an offense in itself to drive a motor vehicle with a BAC of 0.10% or more, without the need

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*See part C. of this chapter.

for proof of any physical signs of drunkenness. The penalties for a violation of this law are the same as for DWI. The second change created the category of driving while ability is impaired (DWAI), a violation of which was made a simple traffic infraction. DWAI is not defined in the statute, but driving with a BAC of .07% or more creates a statutory presumption of impairment. (Section 1195 (b), Vehicle and Traffic Law)

Penalties

A violation for DWI or driving with a BAC of 0.10% or more carries a penalty of up to one year in jail or a fine not to exceed $500, or both. A repeat offender faces from 60 days to 2 years in jail or a fine of $200 to $2000, or both.

A DWAI conviction, a simple traffic offense, carries a jail sentence of up to 15 days or a fine up to $50, or both.

Suspension and Revocation of Licenses

The Commissioner of Motor Vehicles must revoke the license and vehicle registration of a driver who is convicted of DWI or driving with a BAC above 0.10% for at least 6 months. A DWAI conviction carries a mandatory suspension of license and registration for 60 days.

Law Enforcement

Our statutes, as well as the common law, require a policeman to have probable cause to believe a drinking and driving offense has been committed before he can stop a driver on the road. The policeman is asked to make an informed judgment on

the behavior and physical condition of the occupant of another moving vehicle perhaps hundreds of yards away from him.

The policeman has a better chance to make a valid arrest when he happens across a drinking motorist he has pulled over for a traffic violation or comes upon the scene of an accident. In such situations he may validly administer a breath test to every person involved in the accident, without a showing of probable cause. (Section 1193-a, Vehicle and Traffic Law) In other cases an arrest probably will be valid if the officer smells alcohol on the breath of, or notices drunken behavior by, the driver.

In addition to following proper arrest procedures, the police officer must take great care in administering chemical tests to the suspect. The requirements for these procedures are highly technical, and the Department of Motor Vehicles reports that police errors have led to many acquittals and reversals upon appeal.

Over the years, New York prosecutors have found that drunk driving cases are difficult to prosecute to convictions. Juries, they say, are reluctant to convict someone of such criminal conduct. Based upon this experience, only those defendants who have been involved in accidents or have very high BACs (usually above .20%) are brought to trial.*

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*Ford, J.M. et al. Alcohol Abuse and the Criminal Justice System, Center for Governmental Research, Inc., Rochester, N.Y., 1973, p. 80.

Others who are arrested with lower (but illegal) BACs are invariably involved in the plea-bargaining process. In Suffolk County for example, defendants are allowed to plead to DWAI, an offense, instead of DWI, a misdemeanor, with BACs as high as 0.21%.*

It was hoped that the adoption of the per se law would dramatically increase the number of persons convicted of DWI. Since the only issue in that offense is a scientific blood reading, trials could be simplified and the role of the jury minimized.

However, the per se law did not exclude testimony by the police to establish probable cause for arrest, and apparently prosecutors still feel that the juries will continue to acquit defendants in the .10%-.20% range. Their plea-bargaining rules have remained the same.

The extent of the plea-bargaining process is clearly reflected by the following statistics: of 27,000 DWI arrests in 1971, there were only 5200 DWI convictions. In that same year there were almost 10,000 DWAI convictions. Since DWAI is virtually never an original charge, it can safely be assumed that those 10,000 persons were initially charged with DWI.**

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*Testimony of John J. Grennen, District Attorney of Suffolk County, at Joint Select Committee on Transportation hearing, Mineola, October 17, 1974.

**Alcohol Abuse and the Criminal Justice System, supra.

Implied Consent Law

After an arrest is made, the accused driver is required to undergo a chemical test of his breath, blood, urine, or saliva.* A driver may refuse to submit to the test, in which case the test will not be conducted, but the license of the accused must be revoked by the Commissioner of Motor Vehicles for at least six months, following a hearing on the reasonableness of the police actions. By statute, a test refusal may be admissible in evidence at a subsequent trial for drinking and driving.

Re-Issuance of Revoked License

The law requires the Commissioner of Motor Vehicles to revoke the license of a convicted driver for at least six months.** After waiting that period of time following conviction, a driver may re-apply for a license, and a new certificate may be issued at the discretion of the Commissioner. While the Department of Motor Vehicles (DMV) has not published guidelines for the criteria used for license re-issue, Mr. Arnold Fisher, Commissioner of the DMV, has supplied this information to us.***

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*Breath and blood tests are usually used.

**If the driver is under 21, he cannot re-apply until 6 months after his 21st birthday.

***Letter of November 15, 1974.

After the six-month waiting period, the motorist may file his application. The application is reviewed by the technical staff of the Driver Improvement Bureau at the DMV. The review includes such factors as convictions for violation of the Vehicle and Traffic Law, with special emphasis on alcohol-related offenses. If warranted, a field investigation to determine the motorist's drinking habits may be conducted. A decision to approve the application is made only when the Driver Improvement Adjudicator concludes that the subject appears to pose no unreasonable highway safety risk.

In the event of a disapproval by the Driver Improvement Bureau, the motorist may appeal to the Administrative Appeals Board of the DMV. An adverse ruling by the Board may then become the subject of judicial review under Article 78 of the Civil Practice Law and Rules.

Rehabilitation

New York initiated a new approach to the drinking-driver problem in 1968 with the passage of the Experimental Driver Rehabilitation Program. The law, Article 21 of the Vehicle and Traffic Law, provides that drivers who are subject to suspension or revocation of their license because of serious traffic infractions (including drunken driving) may be assigned to rehabilitation programs which last from 10 to 30 hours.

Persons who volunteer to participate in the program have their suspended or revoked licenses returned to them. If

a person fails to meet the attendance or other requirements of the program, the suspension or revocation order is re-issued.

Under the provisions of Article 21, in February of 1969 the Commissioner of Motor Vehicles appointed a Driver Rehabilitation Advisory Board to investigate methods of driver rehabilitation and to set up as experiments appropriate rehabilitation programs based on their findings. In 1970, two pilot programs were begun. The New York City Rehabilitation Clinic opened in June, and a second clinic in Monroe County (Rochester) began in October.

In December 1970, the Board approved the application of the provisions of Article 21 for the rehabilitation program of the Nassau County Alcohol Countermeasure Program, with the requirement that the Nassau program adhere to the guidelines of the Board. This program, one of the Alcohol Safety Action Programs funded by the National Highway Traffic Safety Administration, is restricted to alcohol-related convictions only.

After a proposal submitted by the Automobile Associations of America, the DWI Counterattack Program, also concerned only with alcohol convictions, was approved for operation under Article 21. This program was begun in October of 1971 in Erie, Onondaga and Westchester Counties. These courses, based upon the Phoenix, Arizona DWI course, are educational.

While other counties, such as Dutchess County, do operate other types of educational and rehabilitation programs, more than half of the population of our State does not have

access to such programs. Moreover, in the areas that do have programs, only a small percentage of convicted drivers are eligible to participate because of a lack of space. In Nassau County, for example, only 50% of convicted drivers are eligible.

Proposals for Reform: Department of Mental Hygiene

The Committee on Alcohol and Highway Safety of the New York Task Force on Alcohol Problems has recently studied the problems associated with drinking and driving. The Committee made provisional recommendations in the areas of Public information and education, law enforcement, prosecution, the judiciary, and re-education and rehabilitation of the drinking driver.

Public Information and Education:

1. Develop local data on the problem and prepare fact sheets prior to recruiting volunteer help, especially media help.
2. Interview highway safety program personnel personally to examine the extent of their interest and resources in alcohol and highway safety.
3. Develop a policy of working with local chapters of national organizations rather than dealing directly with their central administrative offices.
4. Plan to use a network of community resources rather than just one agency to assure adequacy and continuity and to avoid a vested interest or fragmented approach.

Law Enforcement:

1. Motivate police personnel to take preventive measures against drinking drivers before accidents occur.
2. Maintain statistics on the incidence of DWI-DWAI arrests, convictions and dismissals, along with data collection on alcohol related crashes.
3. Publish and distribute training bulletins to personnel that provide information on all aspects of alcohol and highway safety.
4. Establish departmental regulations for officers on DWI-DWAI arrest procedures.
5. Conduct periodic training sessions in conjunction with uniform inspections, turnouts, etc.
6. Use breath, blood and urine chemical tests respectively as the priority order for determining blood alcohol levels in motorists.
7. Provide law enforcement personnel with specialized training in the administration of chemical tests.
8. Consider centralization of calibration, maintenance and supply services as methods of increasing breath testing efficiency, along with the use of shared equipment and central location.

Prosecution:

1. Allow the more experienced prosecutors to handle DWI cases.
2. Prepare police officers to become more aware of the evidence available and the need to accurately describe the arrest circumstances when testifying.

3. Have prosecutors make a sincere effort to understand chemical tests procedures so that they are better able to elicit appropriate testimony and counter misleading cross-examination evidence.
4. Convene pre-trial conferences between police and prosecutors so that the latter are made fully aware of the available facts.
5. Ask prosecutors to adhere to the alcohol blood levels used as criteria in the traffic law, and not to pose arbitrary higher standards to increase the disposition of cases.

The Judiciary:

1. Remove traffic infraction cases from the courts to an administrative adjudication procedure developed by the State Department of Motor Vehicles, regardless of whether DWI cases are reduced to an infraction.
2. Establish data processing procedures in the courts to handle records and the processing of cases more efficiently.
3. Consider restricted licenses under appropriate safeguards for occupational purposes for convicted DWI-DWAI violators.
4. Provide literature specifically written for magistrates on recommended procedures for dealing with DWI-DWAI offenders.
5. Convene seminars on DWI-DWAI problems on a regional basis frequently.
6. Consider legislation mandating a minimum five-day jail sentence for driving with a suspended or revoked license or violating a conditional operating license.

7. Consider legislation providing increased permissible penalties for DWI-DWAI convictions.

Re-education and Rehabilitation

1. Require drivers convicted of DWI or DWAI to take a battery of tests, developed jointly by the Department of Mental Hygiene and Motor Vehicles, to reveal relevant conditions associated with drinking and driving behavior.
2. Use the results of the test battery and related procedures to assign DWI and DWAI offenders to a rehabilitative experience designed to serve their needs and change their behavior.
3. Provide a system of differential penalties to increase the motivation of a person convicted of DWI or DWAI to satisfactorily complete a rehabilitation experience.
4. Train alcoholism counselors and other allied personnel to use all appropriate community services for the re-education and rehabilitation of the drinking driver.
5. Establish evaluation programs with adequate criteria and controls to measure outcomes and efficacy for all DWI-DWAI rehabilitation programs.
6. Collect, analyze and organize the results of all DWI-DWAI rehabilitative experiences so as to make a maximum contribution to prevention programs.
7. Direct state highway safety laws and operating policies specifically toward solving drinking driver problems, to assure that proven rehabilitative techniques are used to improve highway safety.

8. Place responsibility for coordinating drinking driver rehabilitation programs in the Department of Motor Vehicles which will provide standards and guidelines to municipalities offering such programs.
9. Authorize courts to impose differential penalties to reflect participation in rehabilitation programs approved by the Department of Motor Vehicles.
10. Provide funding mechanisms to insure a proper level of community and state response to the drinking driver problem.

Proposals for Reform: Center for Governmental Research

In November, 1973, The Center for Governmental Research published a report, "Alcohol Abuse and the Criminal Justice System," for the Genesee/Finger Lakes Regional Planning Board. This detailed and in-depth study of the handling of drinking and driving cases in six upstate counties concluded that available research to date supports a method of handling alcohol-related traffic offenses which combines effective law enforcement with a flexible program of educational and therapeutic procedures (medical, psychological, psychiatric and social work). The report goes on to make the following recommendations:

1. More Effective Law Enforcement. Effective law enforcement is important for three reasons. First, a high perceived probability of being stopped, tested and arrested may at least deter social drinkers. Second, while the threat of arrest may not deter problem drinkers, the probability that these high risk individuals will be detected before

they cause accidents will be increased. Third, the enforcement phase should be considered the intake stage for successful channeling of offenders into treatment variants.

2. Screening of Arrested Offenders. Intake procedures for all arrested persons should be established to permit the gathering of comprehensive information on offenders.

3. Revision of Motor Vehicle and Traffic Law. The present laws making drunk driving a criminal offense have not been enforced by the police nor the courts because the offense is perceived as a social and medical problem, rather than a criminal act. Therefore, administrative, rather than criminal processing of drunk driving offenders should be instituted, at least for the first offense, and that DWI and driving with a BAC of .10% or more be reduced from a criminal misdemeanor to a traffic infraction on the first offense.

4. Sanctions. License suspension and revocation, not jail terms or fines, are the only punitive sanctions which bear a logical relationship to the offense by attempting to remove the driver from the road for a period. In view of this, longer periods of license suspension should be experimented with. The possibility of creating limited licenses should be considered. Finally, the process of reissuing licenses after the period of revocation needs revision. The Department of Motor Vehicles' investigation prior to reissuing licenses should include serious attempts

to determine whether the conditions which precipitated the offense are still present, especially problem drinking. A chronic alcohol abuser who is not receiving treatment should not be issued a license.

5. Referral and Rehabilitation. Even with the improvement of present sanctions against drinking drivers, punitive measures will always have limited value because they do not deal with the underlying medical, psychological and social factors responsible for the offense. A program for enforced therapy for alcoholics should be studied further.

Proposals for Reform: State Traffic Safety Council

The State Traffic Safety Council believes that the effectiveness of the criminal justice system in handling drinking cases can be improved by a review of the conviction rate in comparison to the arrest rate. The number of convictions per year is available from the Department of Motor Vehicles, but there is no state agency which collects data on the number of persons arrested each year. While arrest figures are available for misdemeanor and felony cases, the figures must be obtained from individual counties, and these statistics are often incomplete and are obtained only after long delays. DWAI arrests, because they are classified as traffic infractions, are not reported at all. The Council therefore recommends that all arrests for violations of Section 1192 of the Vehicle Code be reported to a central state agency.

The complex problems associated with the handling of drunk driving cases in the courts were explored in a recent public hearing held in Mineola, L.I., on October 17, 1974. The hearing was jointly sponsored by this Commission, the Joint Select Committee on Transportation, and the Senate Standing Committee on Transportation.

Testifying at the hearing were the following witnesses: Inspector William Morrell, Commanding Officer of Suffolk County Highway Patrol; Peter Gerstenzang, Assistant District Attorney, Albany County; Judge John Edwin Loewy, N.Y. State Magistrates Association; Judge Alfred S. Robbins, Administrative Judge of the District Court of Nassau County; Robert Siek, Lieutenant, New York State Police; Ernest Peace, Attorney, Nassau County; Commissioner Harold A. Adams, Nassau County, Department of Drug & Alcohol Addiction; Donald T. Phillips, New York State Automobile Association; Orman Crocker, Long Island Council on Alcoholism; Julian D. Rivo, Director of Research and Program Development of the N.Y. Traffic Council; Inspector Richard Ketcham, Nassau County Police Department and John J. Grennan, District Attorney, Suffolk County District Attorney's Office.

The witnesses were specifically asked to comment on the following topics:

1. The elimination of the right to a jury trial for the first offender by the reclassification of the first offense as an infraction.

2. The establishment of a pilot project providing for the administrative adjudication of first offenses.

3. The establishment of short-term mandatory jail sentences for all those convicted of drunk driving, or increasing fines.

4. The continuation on a voluntary or mandatory basis of the drunk-driver rehabilitation programs.

5. The establishment of an occupational or restricted use license in New York State.

There was a general consensus among the witnesses against the introduction of occupational licenses for convicted drivers, because such a program would be impossible to administer and enforce. All those who addressed themselves to rehabilitation programs felt they have achieved positive results and should be continued either in place of or in addition to, the punitive penalties.

The witnesses were evenly divided on the third proposition, mandatory jail terms or increasing fines. The proponents generally felt that something has to be done to insure "punishment" of the convicted drivers. Some opponents felt that mandatory sentences would only add another factor which would lead juries to acquit more defendants. The police officers felt that present law provides adequate sanctions if the courts would not hesitate to invoke them.

The greatest controversy surrounded the first and second proposals, the elimination of the right to a jury trial, and the decriminalization of DWI for the first offenders. Judges Morrell and Robbins

D.A. Gerstenzang, Mr. Rivo and, Mr. Adams, strongly supported this proposal.

They expressed their opinion that something must be done to relieve the congestion in the courts caused by the backlog of DWI cases. With the arrest rate skyrocketing and trials taking up many days, the system is reaching the breaking point. In Nassau County, there is a backlog of 5000 DWI cases which is over 25% of the entire criminal caseload. Only one witness, Commissioner Adams, suggested that the current plea-bargaining system be ended, and deplored the fact that more than 85% of arrested drivers plead to traffic infractions.

Mr. John Grennan vehemently opposed any changes in the present system, which is based primarily on plea-bargaining. Even though the legal level of intoxication in New York is .10%, Mr. Grennan's office will accept reduced pleas to DWAI for readings up to .21 %. (Thirty-five percent of the cases get DWI convictions, 62% plead to DWAI and 3% have charges dismissed or are acquitted).

D.A. Gerstenzang proposed that the revocation of driving privileges should be dealt with administratively and separated from the criminal process. In this manner, the arresting officer would confiscate the license temporarily, until the driver has a (civil) hearing before the Department of Motor Vehicles. The Administrator of DMV could then make a simple detemination of driving privileges without regard to any criminal charge.

RECOMMENDATIONS

Pending the completion of a report to the Legislature by the Department of Motor Vehicles on their estimate of the effectiveness of drunk driving programs in this State, this Commission's recommendations based upon the overview presented here, should be, and are, made in principle:

1. The mandatory diversion of drinking drivers to educational programs, such as the one in Dade County, Florida, would appear to serve two purposes:

a. The casual drinker who is convicted of drunk driving may learn the full nature and the consequences of his conduct and how to avoid such conduct in the future; and

b. The problem drinker or alcoholic may be able to come to understand that drunk driving represents only one of several dysfunctions related to the use of alcohol. Recognizing other dysfunctions may be the first step towards developing motivation for treatment.

In this latter context, no countermeasures program could possibly be effective without the incorporation of trained personnel in the helping professions, and also representatives of Alcoholics Anonymous, both to help the individual recognize his problems, as well as to help him secure treatment.

2. Because we are also recommending evaluation of the effectiveness of current treatment approaches to alcoholism, we believe that it would be premature to impose mandatory treatment requirements for convicted drunk drivers, at this

time. However, the voluntary participation of persons in a treatment program for a period of time, and evidence of the alleviation of other alcohol-related problems, might be useful considerations in the determination to restore his license.

3. The reluctance of juries to convict persons charged with drunk driving offenses may be attributable to three causes:

a. Juries identify with defendants, because jurors themselves, tend to drive after drinking. If this is the case, nothing short of a total ban upon the operation of a motor vehicle with any BAC level could possibly be effective as a penal sanction.

b. Jurors do not feel that drunk driving is serious. This seems unlikely.

c. Jurors may have intuited that drunk driving is a medical problem and that the penalty structure is irrelevant to its meaningful solution.

It seems to us that the most likely reading of the difficulty prosecutors report in achieving convictions for drunk driving is this third possibility, that juries believe the problem is not one of appropriate criminal sanctions, but rather, a problem based upon the motivation for and the availability of treatment. Seen in this light, we recommend that further study be given to the following procedure to be used in New York State:

First, empower the police to administer a roadside or a station house chemical test. If the driver fails the test, allow the police to suspend his license, and give him the option

of a criminal proceeding, under the penalty statutes, to clear himself, or a civil proceeding to regain his license.

Second, if the fact of drunk driving is established either way, mandate participation in a countermeasures program for purposes of establishing the eligibility of such an individual to regain his license.

Third, make specific offers of meaningful evaluation and treatment to apparently debilitated or troubled drinking drivers, with a view towards dealing with the underlying causes of their unwanted behavior, and thus, perhaps, reduce the overall problem by the successful outcome of treatment in a significant number of individual cases.

In the event that the Legislature should conclude that a reduction in penalties would lead to a greater number of convictions in drunk driving cases, we would also suggest, as a condition thereof, the enactment of mandatory participation in a countermeasures program, such as the one described in our previous report, Drug Abuse Prevention (cited above).

APPENDIX A

EQUITABLE'S EXPERIENCE WITH DRUG ABUSE AMONG EMPLOYEES AND THE HIRING OF REHABILITATED EX-ADDICTS

Equitable's Experience With Drug Abuse Among Employees And The Hiring of Rehabilitated Ex-Addicts

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Equitable's Experience With Drug Abuse Among Employees And The Hiring Of Rehabilitated Ex-Addicts

During the mid-sixties as the nation became aware of the prevalence of drug addiction among the young, Equitable management sought to determine whether or not this was likely to become a problem among its employees. It sought the opinion of experts in the field. Generally their experience was primarily with hard-core unemployed street addicts. All of the experts stated that drug addiction among employees would not be a problem to the Equitable because young people about to enter the work force could not afford to have an entry level job and support a drug addiction. However, experience proved that a large number of young people who while not addicted are frequent users of heroin and may be habituated. Some of this group have sufficient conventionality to seek jobs. But once employed their life-style and drug habits if unchanged may result in unsatisfactory performance and/or attendance. It was found that their presence tends to encourage "pushing" on the premises, the spread of drug usage to others because of the ready availability and peer pressure, thefts from the company and fellow employees to pay for drugs, and loss of other employees not wishing to be associated with drug users. Because of the clerical nature of the Equitable's operations, accidents were not a problem.

By 1968, because of awareness of drug users among our employee population the Equitable started on its way toward the development of a policy regarding drug abuse among employees.

The stages of policy development for the Equitable were as follows:

1. No company policy regarding drug abuse among employees as it was not seen as a company problem, potential or actual.

2. No written company policy regarding drug abuse among employees although it was considered to be a problem with a very small number of employees. The attitude was to keep alert and dismiss any employee known to be abusing drugs and to refer them to a community drug treatment and rehabilitation center for addicts.

3. Policy not written. Employees known to be abusing drugs were dismissed and at time of dismissal were referred to a specific rehabilitation center organized to handle users and not just addicts. An offer was made to rehire them providing they had not been selling or passing drugs when they completed successfully at least one year of rehabilitation and obtain the recommendation of the rehabilitating agency.

4. Written policy regarding drug abuse. Employees found using drugs and not involved with selling or passing drugs are not fired providing they undergo indicated treatment and rehabilitation. If this can be done without interfering with work, they remain on the job. If working is not possible, the problem is regarded as any other illness and they are returned to work when they are able to work.

The Equitable program for dealing with drug problems among employees is the result of many hours of thought and deliberation by top management and by key individuals in the Medical, Personnel and Security Departments. We are committed to its periodic evaluation and revision as dictated by our own experience and by new knowledge of the problem of drug abuse and better ways of dealing with it.

The Equitable requires all employees to demonstrate reasonable ability to perform the work to which they are assigned and to maintain a reasonable record of on-time attendance and productivity. Drug abuse is only one of a large number of behavioral problems which impair work capacity and performance, increase absence, and have upsetting or demoralizing effects on other employees in the work unit. Included in this group are alcoholism and a variety of emotional and personality difficulties that can have similar effects. Actually, drug abuse accounts for only a small percentage of the behavioral problems we encounter. The essence of our drug abuse program is a clearly stated policy enforced by well defined procedures for implementation contained in a segment of the Equitable's Supervisory Guide to Personnel Policies entitled "Emotional and Behavioral Problems, including Alcoholism and Drug Abuse." A copy is attached.

It is believed that placing drug abuse in a section with a generalized designation has a practical implication. It permits supervisors to be sensitized to impaired performance and unusual behavior among employees reporting to them while relieving the supervisor of the responsibility of trying to diagnose the specific cause. Once identified, the problem employee is referred promptly to the Medical Department. There a diagnosis is made and appropriate treatment and rehabilitation procedures are initiated where indicated.

Specifically, the Equitable's policy on drug abuse and drug traffic is as follows:

1. Drug abuse is a medical problem, and an employee whose abuse of drugs affects his job performance or behavior will be referred to the Employees' Health Center. If the drug abuser is able to function acceptably on the job, has had a previously satisfactory work record prior to drug usage, and sincerely wishes help, Equitable offers to him an opportunity to restore his health and retain his job. If drug abuse has gone so far that acceptable job performance is no longer possible, the employee is placed on disability. He will be continued on disability, with benefits governed by our group benefit coverages, as long as he cooperates fully with the recommended rehabilitation plan and makes progress satisfactory to the Medical Department. If he does not cooperate or does not make satisfactory progress he is dismissed.

   If dismissed, it is with the understanding that he will be considered for re-employment when, in the opinion of the Medical Department, he has been sufficiently rehabilitated to be able to return to work.

2. Employees found selling or passing drugs are dismissed immediately and permanently. The Equitable makes a determined effort to prevent drug traffic on its premises, and in addition to dismissal action it

cooperates with the police and other law enforcement agencies in their efforts to detect and arrest employees involved in drug traffic.

In September 1971, during an officers' meeting the then Equitable President (now Chairman of the Board), J. Henry Smith, explained his feelings about drug abuse, particularly among employees, and explained the new Equitable policy regarding drug abuse. During October 1971, an educational program about drugs and drug abuse was conducted for all employees. Also, a special program for 1,200 middle management employees was held to acquaint them with the policy and the procedures to be employed. About this time, an Equitable publication for employees, Equinews, printed an article describing the emphasis on rehabilitation made by the program. In November 1971, a memorandum went from the President to each employee regarding policy as to drug abuse. A copy is attached.

There is no fixed routine for dealing with employees who are abusing drugs. Rather, each case is considered separately within the framework of our policy and a rehabilitation program uniquely designed to meet the individual's needs is developed. Within the Employees' Health Center, counseling and supportive therapy are offered while the person is referred to an outside community agency for definitive treatment and rehabilitation. We have used a number of agencies; the Department of Psychiatry at the New York Medical College however has been our major resource and most helpful.

As time has passed and supervisors have gained experience with the problem, the general reaction of both younger and older supervisors toward the employee with problems, drug or otherwise, has become

progressively one of understanding and support. This has been particularly true during the last year.

Before there was written company policy, between January 1969 through August 1971, 75 employees were found using heroin and were discharged. Most were referred to treatment and rehabilitation centers. Few took advantage of the referrals. Between September 1971, after the written policy became effective, and October 1974, 23 employees have been found using heroin. Of these, only 8 failed to complete rehabilitation and were discharged. The other 15 entered into treatment and rehabilitation. All did so while continuing actively at work. Of these only 2 required detoxification. The 15 who were rehabilitated while working have done as follows:

5 are still working:

4 for 3 years or more. 3 are doing well and 1 fair.

1 for 2½ years and is doing well.

10 have left our company:

4 for better jobs.

1 to join family on the West Coast to start a new life.

5 were dismissed because of poor attendance or performance.

We have learned from this the importance of the job in motivating drug abusers to accept rehabilitation just as we had previously learned its importance in motivating alcoholics to become successfully rehabilitated.

As our experience in handling drug abuse among employees increased, we felt that we could explore hiring of rehabilitated ex-addicts. We contacted many drug treatment and rehabilitation programs in and around the New York City area and indicated our willingness to consider "graduates" of their programs who they felt were ready for employment. Until 1973 these contacts were disappointing. Most did not bother to follow-up. Some centers were actually visited to emphasize our interest but no referrals for employment were received. Other program representatives were invited to visit the Equitable. Many did but were never again heard from. It became obvious that these agencies had few job-ready clients in spite of their complaints, frequently and loudly voiced through the media, that business and industry discriminated against and would not hire ex-addicts. At that time many other companies were having the same experience. Later, some began to send out resumes of clients to the personnel department to read to see if any were qualified for available jobs. In interviewing these prospective employees it was found that a number of the programs took the word of clients as to their qualifications and working experience without actually verifying it. This resulted in unqualified referrals. Also, in talking to some vocational rehabilitation counselors we found that they, themselves, had never held a regular job. Not only were they sometimes not aware of the basic requirements for employment, but some were actually hostile toward business in general.

Our experience now is that a number of agencies are producing job-ready graduates including some agencies previously found deficient.

The Equitable's criteria for job readiness of people referred from vocational rehabilitation programs are very simple: We require that the

person be interested in working for the Equitable, that he have a reasonable capacity to perform the kind of work that he is seeking, that he be sufficiently motivated to maintain an acceptable level of productivity and on-time attendance, and that he maintain contact with the referring agency for continuing treatment and follow-up.

At present, we now accept job-ready people only from agencies with which we have a good relationship and from which we know we will receive only those people carefully selected from the best "graduates". It is essential that as we attempt to gain experience with the employment of people who are ex-addicts that we select only those most likely to succeed. As we acquire more experience and know more about what we are doing, others can be brought into the program.

Presently, the Equitable will take only a relatively few ex-addicts at a time. This is done in order to assure that each is placed in a unit where he can develop to good advantage and that the Medical and Personnel Departments can offer whatever counseling and guidance might be appropriate. Supervisors have the final say as to whom is hired for a position and everything possible is done by the Equitable's Personnel Department to prepare each program graduate to make the best possible impression on those who are interviewing him.

In our experience, it has been better to tell the supervisor before the interview that the applicant is a person with a history of addiction who has been successfully treated and rehabilitated. Doing this preserves the relationship between supervisors and the Personnel Department and prevents the feeling that Personnel is trying to put something over on

them. Generally, before long on the job, the ex-addict himself tells his colleagues of his past history. The supervisor is told however to keep the new employee's personal history confidential.

Generally, the reaction of a supervisor to the request that an ex-addict be considered for the job is simply, "Can he do the job?" We have come a long way in a short time!

It would be unfair, I feel, to discuss our experience with ex-addicts hired prior to 1973. As previously stated, few agencies knew what "job readiness" was all about initially and we too have learned through experience.

Recently, in order to evaluate our experience with people employed through programs for treatment and vocational rehabilitation of ex-drug addicts, we compared rehabilitated ex-addicts hired during 1973 through October 1, 1974 (the "study" group) with employees not known to have been addicts of the same age, sex, grade and hired as close to the same day as possible (the "control" group). Members of the control group were selected at random and without knowledge of their current status with the company or of how they were regarded by their departments. The comparison revealed:

Ex-Addicts	Performance	Non-Addicts
2	Excellent	0
6	Above Average	4
4	Average	8
1	Below Average	1
1	Poor	1
8	Not Evaluated *	8

*At work less than 4 months

Average Absence Per Quarter

Days

Ex-Addicts		Non-Addicts
2	0	3
5	Less than 1	4
3	1 - 2	2
3	3 - 4	4
1	5 +	1

Average Lateness Per Quarter in Reporting to Work

Times

5	0	11
0	Less than 1	2
6	1 - 2	1
2	3 - 4	0
1	5 +	0

Terminations

Ex-Addicts		Non-Addicts	
Resigned		Resigned	
Disliked job	1	Disliked job	1
To attend College	1	Relocation	1
Better job	3	Better job	1
Personal reasons	1	Job desertion	1
Discharged		Discharged	
Poor Att. and Perf.	1	Behavior on job	1
		Poor Perf.	1
	7		6

Evaluation Period

Ex-Addicts		Non-Addicts
8	More than One Year	9
4	6 - 7 months	3
2	4 months	2

Health Center Visits Per Quarter

2.9	2.0

Because of competition between programs and rivalry between approaches to treatment, one hears many claims on behalf of methadone maintenance or drug free programs depending on whom one is talking to. We found no significant difference between the two groups in our studies.

The Equitable's favorable experience with hiring rehabilitated ex-addicts is not unusual. Throughout the business community those hiring ex-addicts are having similar good experiences. It is urgent that these experiences be pooled in order to provide meaningful statistics. No one employer has enough experience to be able to do this alone. Together, however, there is little doubt that the combined experience will prove significant. The results must be made available to other employers so that they are aware that there is now a group of people available for employment who can make good employees and who are asking only that they be considered on the same basis as any other applicant for employment.

There is great need for representatives of business and industry to work together with those in vocational rehabilitation to further define what is meant by "job-ready" and to assure that graduates so designated

will be more successful employees than those ordinarily applying for jobs.

It is important that there be standardization of quality between the various vocational rehabilitation programs. Perhaps this could be done by accrediting those who are able to produce job-ready graduates. Such accreditation is important in order that business and industry may have guidance as to programs producing the job-ready graduates who may be qualified candidates for employment.

October 31, 1974

APPENDIX B

DRUG ABUSE CONTROL COMMISSION REQUIREMENTS FOR OPERATING A METHADONE PROGRAM

NEW YORK STATE HEALTH DEPARTMENT'S REQUIREMENTS FOR OPERATING A METHADONE PROGRAM

FOOD AND DRUG ADMINISTRATION REGULATIONS FOR THE OPERATION OF A METHADONE PROGRAM

DRUG ABUSE CONTROL COMMISSION REQUIREMENTS
FOR OPERATING A METHADONE PROGRAM

The Mental Hygiene Law of the State of New York requires that the Drug Abuse Control Commission approve in advance facilities and services for the treatment of drug dependent persons. Pursuant to this statutory authority, the Commission has enacted various rules and regulations for operating a methadone program. These requirements pertain to all methadone programs conducted in the State with the exception of operations provided by licensed hospitals or agencies of the State and local governments.

A methadone program is defined as, a person or organization utilizing methadone and any of its derivatives for the detoxification and maintenance treatment for the rehabilitation of narcotic addicts; and conducting initial intake and evaluation of patients at a single specified location and ongoing treatment at the same or other specified locations.

The rules and regulations divide programs into two areas: methadone detoxification and methadone maintenance.

METHADONE DETOXIFICATION

A methadone detoxification program is defined as a procedure using methadone or any of its derivatives to be administered in decreasing doses, over a time period not to exceed 21 days, for the purpose of detoxification from opiates.

All applicants to a methadone detoxification program must be screened by the program staff before admission. The screening process includes:

1. the verification of an applicant's identity (name, address, date of birth, social security number and other identifying data);

2. a determination of opiate or synthetic narcotic addictions, based upon: a physical examination performed by a physician; laboratory evidence (urinalysis), and verification of narcotic abuse and narcotic abuse history, and verification from DACC or its designee that an applicant is not presently a methadone patient in another methadone program.

Once this screening process is completed, the rules and regulations require that the following admission procedure be followed on each applicant:

1. A complete medical history, physical examination, and psychological evaluation;

2.Laboratory workup by a licensed clinical laboratory which includes: (a) routine blood chemistry; (b) liver profile; (c) serology to determine the presence of communicable disease; (d) complete blood count; (e) routine urinalysis;

3. Intake interview and complete psycho-social history, taken by a counselor, social worker or licensed professional medical staff member;

4. "Consent to Methadone Treatment" (FD 2635) form to be signed by applicant, or by his parent or legal guardian if the applicant is under 18 years of age;

5. Issuance of an identification card with beginning and termination dates of validity prominently set forth on the face thereof, and valid for no more than a total of 21 days.

Except in emergency cases, no methadone can be administered unless the applicant has been determined to be an opiate addict* and has undergone all the screening and admission procedures required. In emergency cases, methadone can be administered after the submission of a clearance inquiry of specimens, and pending return of enrollment clearance reports from the commission or its designee, or clinical laboratory reports. Programs are called upon to discourage repeated or prolonged exercise of this privilege by any single patient.

Only a physician may determine the patient's initial methadone dose, detoxification schedule, and any departure from the prescribed dose or schedule. The physician must communicate the dose to the pharmacy or nurse supervising medication, and any oral communication must be confirmed in writing within 72 hours. The current dosage of each patient must be entered on his medical chart.

Methadone cannot be administered at a detoxification facility until the patient has been identified and the dosage compared with his currently ordered and documented dosage level. The physician or nurse administering the medication must observe its ingestion which must be taken orally.

*DACC interprets primary methadone addiction as opiate addiction.

METHADONE MAINTENANCE

Methadone maintenance, a procedure defined in the rules and regulations as using methadone and any of its derivatives, to be administered over a period of time in excess of 21 days, for the purpose of maintaining patients at a stable dosage or by slow reduction of the dosage to achieve a drug-free state.

All prospective methadone maintenance patients must be screened by the intake staff to determine eligibility. This process includes the verification of the applicant's identity (name, address, date of birth, social security number and other identifying data), and a determination of opiate or synthetic narcotic addiction. That determination must be based upon: a physical examination performed by a physician; laboratory evidence (urinalysis); verification of narcotic abuse and narcotic abuse history. Additionally, DACC must verify that the applicant is not presently a methadone patient in another methadone program.

The following procedures are required to admit an applicant to a methadone program:

1. a complete medical history, physical examination, and psychiatric and psychological evaluation; (2) laboratory workup which includes routine blood chemistry, liver profile, serology, complete blood count, and routine urinalysis; (3) a test for tuberculosis, with follow-up, if indicated; (4) current tetanus immunization; (5) intake interview and complete psycho-social history by a counselor or social worker; (6) "Consent to Methadone Treatment" (FD2635) form to be signed by applicant or if he is under

18 years, by his parent or legal guardian; (7) the issuance of an identification card with photo. In addition, all these medical procedures must be repeated annually.

Except in emergency cases, no methadone can be administered unless the applicant has been determined to be an opiate addict and has undergone all the screening and admission procedures required. In emergency cases, methadone can be administered after the submission of a clearance inquiry or of specimens, and pending return of enrollment clearance reports from DACC or its designee, or clinical laboratory reports. Programs are asked to avoid repeated or prolonged exercise of this privilege by any single patient.

Only a physician may determine the patient's initial dose, detoxification schedule, any any departure from the prescribed dose or schedule. The physician must communicate the dose to the pharmacy or the nurse who supervises medication. Any oral communication must be confirmed in writing within 72 hours. The current dosage of each patient must be entered on his medical chart.

Methadone cannot be administered at a maintenance facility until a patient has been identified and the dosage compared with his currently ordered and documented dosage level. The nurse or physician administers the medication orally and must observe its ingestion. The dosage supplied cannot exceed 120 milligrams. All take-home bottles must contain individual doses and be labeled in accordance with Federal and State regulations. Caps must be child-proof and labels orange. The doses supplied in the clinic cannot exceed 120 milligrams and those for take-home no more than 100 milligrams.

The following are the criteria relating to the frequency of clinic visits: (1) If the patient has been admitted less than three months, he is required to visit the clinic at least six days a week. One take-home dose is allowed per week. (2) If he is admitted longer than three months but less than two years, at least three weekly visits are required. Gradually, his take-home dosage may increase to four times per week, but no more than two doses can be given at any one time. (3) If he is in treatment more than two years, two clinic visits per week are required. Five take-home doses are permitted weekly, but a maximum of only three doses may be given at any one time.

All take-home bottles must contain individual doses which are not to exceed 100 milligrams. Caps must be child-proof. Labels must be orange and must be in accordance with Federal and State regulations.

In addition to the foregoing mandatory criteria, the privilege of receiving more than one take-home dose weekly is subject to a showing of probable responsibility in the handling of a potent pharmaceutical product.

The take-home privilege must be immediately withdrawn if: (1) two or more consecutive urine specimens are negative for methadone, or (2) there is credible evidence of diversion of methadone; (3) the patient has lost his methadone on more than one occasion within any monthly period.

The following forms of behavior would indicate a need for increased clinic visits and should be considered by the program: (1) abuse of controlled substances as evidenced by patient's statements, physical examination, positive urinalysis for non-prescribed drugs; (2) falsification of urine speciment; (3) self-administration of methadone in a way other than prescribed; (4) irregular attendance; (5) refusal to participate in other program components, if such

participation is deem necessary by the professional staff; (6) acting-out behavior including violence or threats of violence; (7) evidence that the patient is involved in other inappropriate behavior.

DACC has the power to grant exceptions to the mandatory clinic visit criteria, but such approval must be fully documented and reveiwed monthly. In the following exceptional circumstances, notification of DACC, but not its prior approval, is required: acute illness, family crises, emergency travel, holidays. However, a patient can never be issued more than a six-day supply.

A medical examination by a physician or nurse is required daily during the induction stabilization stage of treatment. Following stabilization, for one month, a weekly examination is required. Subsequently, each patient must be examined at three-month intervals on a regularly scheduled basis. Additionally, medical services must be readily available to the patients during clinic hours.

It is mandated that in addition to medical services, each methadone treatment program must provide a comprehensive range of rehabilitation services on-site under professional supervision. These are individual, group, and vocational counseling. In addition, the facility must have documented formal agreements with other individuals or agencies, so that a patient requiring more sophisticated services can be referred to, at minimum, the following services: surgical, psychiatric, family planning, child placement, marriage counseling, family therapy, psychological consultation and legal assistance. All such referrals and follow-up in-

formation and reports must be entered into the patient's record.

A weekly urine speciment is required from each patient. Specimens are acquired in accordance with a randomization schedule, prepared in advance. Each specimen must be collected under the direct visual observation of a staff person. Another collecting method may be approved if it can be demonstrated that such method is effective in minimizing the possibility of falsification. Results of urinalysis must be entered in chronological order in both the patient's medical and in his counseling records.

Interdisciplinary staff conferences must be scheduled weekly. Based upon the responses of individual patients to the program and staff recommendations, appropriate changes in treatment or patient status are to be determined at the conference.

Each conference, recommendation and decision must be recorded in the patient's record. After one year of treatment, the appropriateness of continued methadone maintenance treatment must be evaluated. The specific medical and rehabilitation rationale behind the result of the evaluation is to be recorded in the patient's record.

Evaluations are to be repeated annually. All staff conferences will review evidence of problems which may become manifest in the form of physical illness, symptoms related to methadone ingestion, persistent drug abuse (in particular the habitual ingestion of barbiturates, amphetamines and other non-opiate habit-forming drugs), repeated abuse of alcohol, violent acting-out inside and outside the clinic, anti-social behavior, and repeated infrac-

tions of clinic rules and regulations. All these disorders must be considered as part of the patient's pathology, and the appropriate treatment or referral for treatment arranged. After a reasonable period of time, an interdisciplinary case conference shall decide whether or not a specific patient can benefit from continued methadone maintenance treatment and whether continuation of such treatment constitutes a risk to himself or others. Where continuation in methadone maintenance is deemed inappropriate, the staff has to explore which treatment modality other than methadone would be available to the patient, and seek the patient's consent to agree to such referral. In any case, the staff shall make available to the patient an opportunity for detoxification from methadone either as an in-patient or an out-patient according to medical indication and subsequently discharge him from the methadone maintenance treatment program. All case developments, recommendations, case decisions, referrals and reactions of the patient shall be carefully recorded, and the reasons for the decision to terminate him shall be explained if detail in the closing summary.

A detoxification procedure must be provided to all patients who request it, and to any patient who, by staff decision, is no longer a suitable methadone maintenance patient. In cases where it has been determined that on-site detoxification is undesirable (e.g. patient's violent behavior), alternative arrangements for in-patient or out-patient detoxification may be made at another facility. If such arrangements are rejected by the patient and suitable documentation has been included in the patient's record, the program's responsibility will have been discharged.

Each methadone maintenance program must have the services of a physician, a clinic administrator, supervising-nurses, counselors, and a vocational specialist.

The equivalent of one full time physician (35 hours) for every 300 patients is required. If not present during some clinic hours, he must be available for consultation and emergency attendance. To qualify for this position, the physician must have a New York State license, specific training or direct experience in the treatment of narcotic addicts with methadone, and a well-grounded familiarity with accepted rehabilitative modalities.

One full-time clinic adminstrator-supervisor is mandated for a clinic of up to 300 patients. Such person must hold a master's degree in one of the behavioral sciences or social work or he must have had direct or progressively responsible experience in the operations of a narcotic treatment program. If a clinic is authorized to treat more than 300 patients, the duties of the administrator-supervisor are to be divided into two positions - a clinic administrator (having administrative experience) and a case supervisor (same qualifications as required for administrator-supervisor).

The clinic administrator will be responsible for the ongoing supervision of administrative functions, and the training of all staff in administration and for the training and supervision of all counseling staff. In those clinics with less than 300 patients, the clinic administrator-supervisor will assume all of the above responsibilities.

There can be no less than the equivalent of two full-time registered or licensed practical nurses for up to 300 patients. Where specific approval to serve over 300 patients has been granted,

there shall be one nurse for each additional 100 patients or fraction thereof. The nursing staff must include one registered nurse who is responsible for the general supervision of the nursing staff. The total number of nurses on the staff must be commensurate with the clinic hours and the number of patients to be served in order to insure that adequate nursing care will be provided at all times the clinic is in operation. Methadone shall be administered under a nurse's direct observation and control.

There must be one full-time counselor (bachelor's degree or high school graduation or equivalency diploma coupled with two years or more of experience as a para-professional rehabilitation worker) for every 50 patients. Patients are to be assigned to specific counselors.

Additionally, one full-time vocational specialist (bachelor degree and experience in vocational counseling) is required for every 150 patients.

RECORDS - FOR DETOXIFICATION AND MAINTENANCE

An individual consolidated record shall be maintained for each patient. It must contain: (1) identifying data and initial interview report, which include: residence, family relationships and attitudes, education and vocational history, data on military service, if any, legal record, history of drug abuse and drug abuse treatment, intake worker's impressions and recommendations for immediate and long-range treatment; (2) medical reports, laboratory reports and progress notes to be entered by physicians

and nurses; (3) reports of urine tests for drugs of abuse; (4) dated case entries of all contact with or concerning patients including a record of each clinic visit in chronological order; (5) date and results of case conferences (maintenance patients only; (6) quarterly progress reports including a narrative summary of the patient's response to treatment during the report period, recommendations for changes in treatment, if indicated (maintenance patients only); (7) clearance with the methadone data processing center, date and result; (8) correspondence with patient, family members, other individuals, and referral agencies; (9) closing summary including reason for termination and referral, if any. In the case of death, the cause of death shall be documented and reported to DACC.

SECURITY

Each visit by every patient must be recorded in chronological order. Data as to the current dose of methadone for each patient will be immediately available in the patient's record. Each prescription for methadone must be written on an acceptable order sheet and signed by the physician. Each dosage dispensed, prepared, or received must be recorded and accounted for by written signed notation in a manner which will achieve a perpetual and accurate inventory of all methadone in stock at all times. Every dose of methadone must be recorded on an administration sheet at the time that the dose is administered or dispensed and also on the patient's individual medication sheet. The qualified person administering or dispensing methadone must sign his or her name at each notation.

The methadone will be totaled in milligrams daily.

Methadone storage areas must be secured, with access limited to properly authorized staff. If individual doses of methadone are prepared in the clinic, the location for such an operation must be securely and visually separated from patient areas. Immediately after administration, containers are to be purged by rinsing, inversion, or by an acceptable alternative method which will effectively prevent the accumulation of residual methadone. Used containers are to be destroyed. This applies both to those used in the clinic as well as to all take-home bottles dispensed to patients in maintenance-type programs. Maintenance patients are required to return take-home bottles before receiving further take-home medication.

PHYSICAL FACILITY

No methadone clinic shall serve more than 300 patients at any time, unless approved for a greater capacity, after review, by DACC. Criteria for such approval includes, but not limited to, the state of treatment of the patients, services offered, and needs of the community served.

The methadone clinic facility must be large enough to serve comfortably the number of patients it has under treatment. It must have a waiting area, physician's office and examination room, a nurse's station with a methadone dispensing window or counter, and individual offices for clinic supervisor, counselors, and other treatment personnel. Adequate room must be available for group counseling and conference purposes.

The medical area of the clinic must contain, at least, the following equipment and supplies: (1) furniture--examining table, instrument and drug cabinet, desk and chair; (2) supplies--medical instruments suitable to required examinations and foreseeable emergency procedures, including as a minimum, sphygmomanometer, otoophthalmoscope, and stethoscope; (3) emergency equipment--Narcan with instructions for use, oxygen, manual and mechanical resuscitator, and emergency tray.

The methadone clinic shall be open at least six days per week. Dispensing hours are to be flexible enough to permit a patient who is working, attending college or pursuing other socially acceptable activities to receive methadone without jeopardizing his status. Clinic hours should be so arranged as to permit a free flow of patients.

The medication closet at the nursing station must properly separate medications for internal and external usage. All expired or deteriorated medication must be removed. Each container of medication must be properly labeled, and must indicate the appropriate stock number. All locks must be in proper operating condition, with a double-locked narcotics compartment. There must also be frequent and regular checks of medication, in addition to frequent spot checks. A daily narcotic sheet is required.

All medication requiring refrigeration must be properly stored in efficiently operating locked refrigeration units. Doors in the dispensing area must have deadbolt or slide-bolt locks with double-locking in medication areas. A list of all personnel possessing keys to the medication areas must be maintained, with proper safe-

to be employed for the transfer of keys from one tour of duty to the next, and for the safekeeping of such keys. An adequate alarm system must be maintained, and there is to be sufficient capacity for telephone communication through the clinic.

PROCEDURAL REQUIREMENTS

Community considerations require each program to define and report to DACC the geographic area of residence or employment from which its caseload is drawn. Approval for the operation of the clinic is dependent upon a favorable determination pursuant to the Public Health Law of issues of community concern including public need.

The granting or continuation of an approval by DACC is conditional upon conformity by the applicant with all relevant Federal, State, and local laws and regulations.

If a program desires any exemption from strict compliance from the rules and regulations, such request must be addressed to DACC in writing stating the reasons for the variance. DACC will give written reasons for a denial of such requests.

If a program is not in strict compliance with one or more of the requirements, approval nonetheless may be granted conditionally if in the public interest.

If approval is denied or revoked, a public hearing on the matter may be requested, and will be conducted by the chairman or his designee of the commission.

If an application is denied or revoked, it can only be resubmitted by permission of DACC and only for good cause.

No applicant can be admitted to a methadone program if he is reported to be participating in another such program.

To prevent simultaneous enrollment, a clearance inquiry of each applicant must be submitted to DACC. This form must contain the name, address, date of birth, social security number of the applicant, his dates of application, admission discharge or termination. These reports will be treated as confidential information by DACC.

The confidentiality provisions of the Drug Abuse Treatment Act of 1972 pertain to all patient records and reports maintained under the rules and regulations.

Members or staff of DACC shall be allowed to inspect the premises, facilities, staff, patients and records of each approved program at reasonable times. Refusal to permit such inspection may constitute cause for revocation of approval.

NEW YORK STATE HEALTH DEPARTMENT'S REQUIREMENTS FOR OPERATING A METHADONE PROGRAM

The Controlled Substances Act (Article 33 of the Public Health Law) regulates the lawful use of dangerous drugs in New York State.

The New York State Department of Health is the agency responsible for the administration of this law. That department, pursuant to its broad regulation powers, has enacted various rules and regulations which, in addition to the law itself, govern the dispensing of methadone to narcotic addicts.

Only treatment programs for detoxification and maintenance of addicts which are certified by the Health Department may dispense methadone to patients.

APPLICATION & AUTHORIZATION

Before the Health Department can act on an application, the applicant treatment program must demonstrate that it holds valid operating authorization from the New York State Drug Abuse Control Commission and the United States Food & Drug Administration.

During its consideration of an application, the Department must afford DACC, the Regional Hospital Review and Planning Council and the areawide comprehensive planning agency the opportunity to submit their recommendations. The Department is also required to consult with DACC before it approves or disapproves an application.

Each applicant must file a detailed protocol which sets forth the qualifications of the sponsor, the nature and objectives of the proposed program, the number of patients to be treated, the administration criteria, and the availability of facilities for evaluation and rehabilitation of patients in the program.

Concept sketches of the physical facility must be submitted in the application. These must be single line free-bond sketches of each floor in an appropriate scale, showing the relationship of the various departments or services to each other. Major exit corridors, exit stair locations and the flow of people must be indicated.

The application must also include copies of all papers filed with any Federal agency whose approval is required. Additionally, the applicant program must submit any other information that the Health Department may require.

Applicant maintenance programs must also submit proof of the following: (1) the sponsor is ready, willing and able to properly carry on such a program; (2) the sponsor will be able to maintain effective control against diversion of methadone; (3) it is in the public interest that a license be granted and that there is a public need for the program at the time and place and under the circumstances proposed; (4) the sponsor and staff are of good moral character and competence and (5) the sponsor is able to comply with all applicable State and Federal laws.

The approval of a program is contingent upon an on-site visit by Health Department investigators to assure that all re-

quirements are complied with. A request for such inspection must be submitted forty-five days before the anticipated commencement of services.

The license of a maintenance program is temporary. It is the duty of the sponsor of such a program to amend its application to reflect any important program change.

A license may be revoked, suspended or limited upon failure of a program to comply with applicable State or Federal laws and regulations.

PROGRAM STRUCTURE

The Department requires that the physical facilities of a treatment program be sufficiently large and properly maintained to provide appropriate conditions for the treatment, counseling, and handling of patients. The facility must include, at minimum, a waiting room, a nursing station with a secure area for controlled substances, two toilets with access visible from the nurses' station, a doctor's office with adjourning treatment room, an office for counseling and counselors, an administration office, and space to provide adequate circulation of patients. A minimum of 1,000 square feet of floor space must be provided for 150 patients and must be increased by five square feet for each patient enrolled above that number.

Enrollment in a treatment program cannot exceed 300. Permission may be granted to exceed this number, but only if special circumstances exist, and only for a specified period of time. The Department, in reviewing a request for an extension of enrollment

must consider the following factors: (1) the need for expanded treatment programs in the area served by the sponsor; (2) the ability of the program to organize its services so that each patient receives effective and required services on a personal basis; (3) evidence of the program's history of operation in the community; (4) evidence that refusal to grant such request would create extreme financial hardship because of prevailing leasehold agreements, or other contractual agreements not subject to termination or renegotiation; (5) other pertinent matters which the Department might require.

The practitioner or program sponsor must provide evidence of prior training in the treatment of narcotic addiction. The supervising physician must be of good character, competence and standing in the community and have demonstrated a reputation for having practiced medicine in an ethical manner.

The sponsor must develop a policy manual covering all aspects of the operation of the program and provide continuing instruction of all staff members regarding the objectives, plan of operation, and methods of evaluation for the program.

A comprehensive medical evaluation for each patient at the time of admission must be provided and thereafter each patient in the program must be offered continuing medical care comparable to that rendered by a general practitioner. Provision must be made for additional required diagnostic and therapeutic services to be provided either by consultant physicians attached to the program, or by referral of the patient to a comprehensive medical facility.

There must be a formal, documented agreement between the sponsor and an approved hospital demonstrating that hospital care, both inpatient and comprehensive ambulatory care, is fully available to any patient who may need it.

When an acute medical problem arises it is the responsibility of the program sponsor, where required, to provide or arrange for immediate emergency medical care including hospitalization and arrange for appropriate transportation.

Loitering by patients near the program entrance, in the program itself or in the immediate vicinity of the program cannot be permitted.

Staff must be adequate to maintain proper order in and about the premises.

The program must be open at least six days a week and office hours must be clearly posted. A receptionist and waiting room with sufficient chairs for patients must be provided. There must be an orderly system for the flow of patients and an adequate internal system for identifying patients.

The nursing station at which methadone is dispensed must have an adequate supply of Narcan, a narcotic antagonist (naloxone), and equipment required for its administration. General medical standards of sanitation must be in effect. Bathrooms must have soap available and cloth or paper towels for individual use. No animals are allowed within the office. Fire extinguishers must be available at appropriate locations.

Methadone maintenance programs must submit monthly reports summarizing their activities the previous month. This report must

include: (1) An inventory of the quantity of methadone at the beginning and end of each month; (2) the quantity of methadone received, from who each order was received, and the form or dosage unit in which the drug was received; (3) the quantity of methadone prescribed, dispensed and administered; (4) the name and address of each applicant admitted or awaiting admission; (5) each incident or alleged incident involving the theft, loss or possible diversion of methadone.

All treatment programs must submit to the central registry of the Department the name and other identifying data of each reported addict, and the status of each addict awaiting admission to an approved program. All records of a program which would identify a particular patient must be kept confidential within the Department and DACC.

All certified programs must promptly notify the Department of each incident or alleged incident of the theft, loss or possible diversion of methadone. Also, the Department must be notified of any charges or proceedings brought in any court or before any governmental agency, relating to the failure of a program to comply with State or Federal methadone regulations.

All treatment programs must comply with the conditions of use of methadone as set forth by the Food and Drug Administration and the Drug Abuse Control Commission.

FOOD AND DRUG ADMINISTRATION REGULATIONS
FOR THE OPERATION OF A METHADONE PROGRAM

Programs which desire to treat narcotic addicts via the use of methadone must be approved by the FDA. While the rules and regulations in this area are rather detailed and comprehensive, they are only minimum standards. The FDA regulations reflect the coordinating effort between the Federal and State governments for the treatment and rehabilitation of narcotic addicts. Reference is frequently made to the "State Authority" (DACC in New York) which is given certain responsibilities under the Federal law. Since the states have the primary responsibility for the treatment of addicts, their rules and regulations can be more restrictive than the FDA's.

A methadone treatment program is defined as a person or organization which furnishes a comprehensive range of services using methadone for the detoxification and maintenance treatment of narcotic addicts.

Detoxification treatment is defined as the administering or dispensing of methadone as a substitute narcotic drug in decreasing doses to reach a drug free state in a period not to exceed 21 days in order to withdraw a person who is dependent on heroin or other morphine-like drugs from the use of these drugs.

Maintenance treatment is defined as the continued administering or dispensing of methadone, in conjunction with the provision of appropriate social and medical services, at a relatively stable dosage level, for a period in excess of 21 days as an oral substitute for heroin. An eventual drug-free state is the treatment goal but it is recognized that for some patients the drug may be needed for long periods of time.

APPLICATION PROCEDURE

The program sponsor or private practitioner (physician) must submit an application in triplicate to operate a methadone program simultaneously to the FDA and DACC. (However, before the FDA will act on an application, it must receive notification that the program has satisfied all State requiremnts and has received approval to operate from DACC.)

The application is form FD-2632, "Application for Approval of Use of Methadone in a Treatment Program". This rather lengthy application must include:

a) The name, address and a summary of the scientific training and experience of each physician and all other professional personnel having major responsibilities for the program;

b) A description of the organizational structure of the program and the name and address of any central administration or larger organizational structure to which the program is responsible;

c) A list of the funding sources of the program;

d) The name, address and description of the medical facilities to which the program has ready access for comprehensive medical and rehabilitative services;

e) A statement of the approximate number of addicts to be included in the program.

In addition, an applicant must agree to adhere to all the rules, directives and procedures set forth in the regulations. These regulations can be grouped as follows: organization, staff, admission, drug dispensing, attendance and take-home privileges, records and miscellaneous.

ORGANIZATIONAL REQUIREMENTS

Treatment programs must provide in addition to methadone dispensing, counseling, rehabilitative and other social services which will help the patient become a well functioning member of society. Such supportive services should be made available at the primary facility (where methadone is administered). However, if formal agreements exist, these services may be offered elsewhere.

Hospital care for drug-related problems must be available to any patient. While not mandatory, it is suggested that each program have formal arrangements with a hospital to provide general medical care to patients. Neither the program nor the hospital are required to assume financial responsibility for a patient's medical care.

Programs are permitted to refer certain patients to a "medication unit" for the dispensing of methadone. Such facilities can be utilized if the program determines that a patient is not in need of frequent counseling, rehabilitative and other services which are available at the primary program facility. These units can be established in private physicians' offices or in community pharmacies. However, after a referral, the program is still responsible for the patient's care. The referred patient must recieve needed medical and social services at least monthly at the primary facility.

Each medication unit must be approved by the FDA and DACC. Approval will be based on the distribution of these units within a particular geographic area. Methadone will be supplied by the primary facility to the medication unit out of its stock of the drug.

STAFFING

Each program must have a program sponsor who must take primary responsibility for the program and its employees. The sponsor must agree to inform all his employees of all rules and regulations and to monitor their activities to assure compliance with the provisions. While the sponsor need not be a physician, he must employ a licensed physician as the medical director of the program.

The medical director must submit form FD-2633 "Medical Responsibility Statement for Use of Methadone in a Treatment Program". This form includes the names of all persons who will administer or dispense methadone for the program.

At least one full-time physician must be retained by the program. In addition, two nurses and four counselors are required for every 300 patients receiving treatment.

ADMISSION STANDARDS

Each prospective patient must be fully informed of the possible risk associated with the use of methadone. Participation in a program must be voluntary, and all patients must sign, with full knowledge and understanding of its contents, form FD-2635 "Consent for Methadone Treatment". Minors must have a parent or guardian co-sign.

Care must be exercised in the selection of patients to prevent the possibility of admitting a person who was not first dependent upon narcotics at least two years prior to admission to maintenance treatment. Evidence of physical dependence should be obtained by noting early signs of withdrawal during the initial period of abstinence. Withdrawal signs may be observed during an initial period of hospitalization or while the individual is an outpatient undergoing diagnostic evaluation (e.g. medical and personal history, physical examination and laboratory studies). Additional evidence can be obtained by noting the presence of old and fresh needle marks, and by obtaining additional history from relatives and friends.

Under exceptional circumstances, a deviation from the requirement for current physical dependence will be allowed. An example would be a patient who has recently been released from a penal institution who has a predetention history of narcotic dependence.

Under no circumstances may minors under age 16 be admitted to a maintenance program. Patients between the ages of 16 and 18 can be admitted only under limited conditions. These persons can be admitted only with a documented history of dependence on narcotics beginning 2 years or more prior to application for treatment. Parental consent is required.

Patients under 16 years may be detoxified, but a repeat episode of detoxification may not be initiated until 4 weeks after the completion of the previous detoxification.

Even if a patient meets the admission standards, he may be refused treatment by a program if the medical director determines that a particular patient would not benefit from methadone treatment.

DISPENSING OF METHADONE

Methadone can only be dispensed and administered in liquid form orally. Only a licensed physician or his authorized agent (pharmacist or nurse) may administer the drug. All take-home medication must be labeled with the treatment center's name, address and telephone number.

In detoxification the patient may be placed on a substitutive methadone administration schedule when there are significant symptoms of withdrawal. The dosage schedules indicated below are recommended but could be varied depending upon clinical judgment. Initially, a single oral dose of 15-20 milligrams of

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methadone will often be sufficient to suppress withdrawal symptoms. Additional methadone may be provided if withdrawal symptoms are not suppressed or whenever symptoms reappear. When patients are physically dependent on high doses of methadone, it may be necessary to exceed these levels. Forty milligrams per day in single or divided doses will usually constitute an adequate stabilizing dose level. Stabilization can be continued 2 to 3 days and then the amount of methadone will normally be gradually decreased. The rate at which methadone is decreased will be determined separately for each patient. The dose of methadone can be decreased on a daily basis or in 2-day intervals, but the amount of intake must always be sufficient to keep withdrawal symptons at a tolerable level. In hospitalized patients a daily reduction of 20 percent of the total daily dose usually will be tolerated and will cause little discomfort. In ambulatory patients, a somewhat slower schedule may be needed. If methadone is administered for more than 3 weeks, the procedure is considered to have progressed from detoxification or treatment of the acute withdrawal syndrome to maintenance treatment, even though the goal and intent may be eventual total withdrawal.

In maintenance treatment the initial dosage of methadone*should control the abstinence symptoms that follow withdrawal of narcotic drugs, but should not be so great as to cause sedation, respiratory depression, or other effects of acute intoxication. It is important that the initial dosage be adjusted

*15 to 20 milligrams

on an individual basis to the narcotic tolerance of the new patient. If such a patient has been a heavy user of heroin up to the day of admission, he may be given another 20 milligrams 4 to 8 hours later, or 40 milligrams in a single oral dose. If he enters treatment with little or no narcotic tolerance (e.g. if he has recently been released from jail or other confinement), the initial dosage may be one-half these quantities. When there is any doubt, the smaller dose should be used initially. The patient should then be kept under observation, and, if symptoms of abstinence are distressing, additional 10 milligram doses may be administered as needed. Subsequently, the dosage should be adjusted individually as tolerated and required, up to a level of 120 milligrams daily. For daily dosages above 100 milligrams patients must ingest medication under observation 6 days per week. These patients will be allowed take-home medication for 1 day per week only. A daily dose of 120 milligrams or more must be justified in the medical record. For daily dosages above 120 milligrams, prior approval from DACC and FDA must be obtained. For take-home doses above 100 milligrams per day, prior approval from DACC and the FDA must be obtained. A regular review of dosage level should be made by the responsible physician with careful consideration given for reduction of dosage as indicated

on an individual basis. A new dosage level is only a test level until stability is achieved.

Caution must be taken in the maintenance treatment of pregnant patients. Dosage levels must be maintained as low as possible if continued methadone treatment is deemed necessary. It is the responsibility of the program sponsor to assure that each female patient is fully informed concerning the possible risks to a pregnant woman or her unborn child from the use of methadone.

ATTENDANCE AND TAKE-HOME RULES

For detoxification, the drug must be administered daily under close observation. In maintenance treatment the patient will initially ingest the drug under observation daily, or at least 6 days a week for the first 3 months. It is recognized that diversion occurs primarily when patients take medication from the clinic for self-administration. It is also recognized, however, that daily attendance at a program facility may be incompatible with gainful employment, education, and responsible homemaking. After demonstrating satisfactory adherence to the program regulations for at least 3 months, and showing substantial progress in rehabilitation by participating actively in the program activities and by participation in educational, vocational, and homemaking activities, those patients whose employment, education, or homemaking responsibilities would be

hindered by daily attendance may be permitted to reduce to three times weekly the times when they must ingest the drug under observation. They must receive no more than a 2-day take-home supply. With continuing adherence to the program's requirements and progressive rehabilitation for at least 2 years after entrance into the program, such patients may be permitted twice weekly visits to the program for drug ingestion under observation with a 3-day take-home supply. Prior to reducing the frequency of visits, documentation of the patient's progress and the need for reducing the frequency of visits must be recorded. The requirements and schedule for when the drug must be ingested under observation may be relaxed if the patient has a serious physical disability which would prevent frequent visits to the program facility. The FDA and CACC must be notified of such cases. Additional medication may also be provided in exceptional circumstances such as acute illness, family crises, or necessary travel when hardship would result from requiring the customary observed medication intake for the specific period. In these circumstances the reasons for providing additional medication will be recorded. In circumstances of severe illness, infirmity or physical disability, an authorized individual (e.g. a licensed practitioner) may deliver or obtain the medication.

In maintenance treatment, a urinalysis will be performed randomly at least weekly for morphine and monthly for methadone, barbiturates, amphetamines and other drugs if indicated. Those patients receiving their doses of the drug from medication units will also adhere to this schedule. The urine must be collected

at the program's primary facility or at the medication unit.

Urine must be collected in a manner which minimizes falsification of the samples. The reliability of this collection procedure must be demonstrated.

Laboratories used for urine testing must participate in and be approved by any proficiency testing program designated by the FDA. Any changes made in laboratories used for urine testing must have prior approval of the FDA.

RECORDS

An admission evaluation and record must be made and maintained for each patient upon admission to a program. These must consist of a personal and medical history, physical examination, and any laboratory or other special examinations indicated. It is recommended that a complete blood count, liver function tests, and a serologic test for syphilis be part of the admission evaluation.

An adequate clinical record must be maintained for each patient. It must contain a copy of the consent form, the date of each visit, each missed appointment, the amount of methadone administered or dispensed, the results of each urinalysis, a detailed account of any adverse reactions, and significant physical or psychological disability, the type of rehabilitation and counseling efforts employed, an account of the patient's progress, and other relevant aspects of the treatment program. An evaluation of the patient's annual progress must be recorded as well.

Accurate records traceable to specific patients must be maintained to show dates, quantity, and batch or code marks of the drug dispensed. These records are to be retained for a 3 year period.

MISCELLANEOUS REQUIREMENTS

All patients in treatment will be given careful consideration for discontinuation of methadone use, especially after reaching a 10-20 milligram dosage level. Social rehabilitation must have been maintained for a reasonable period of time. Patients should be encouraged to pursue the goal of eventual withdrawal from methadone and becoming completely drug free. Upon successfully reaching a drug-free state the patient should be retained in the program for as long as necessary to assure stability in the drug-free state, with the frequency of his required visits adjusted at the discretion of the director. Maintenance treatment using methadone must be discontinued within 2 years after such treatment is begun unless, based upon clinical judgment recorded in the clinical record for the patient, the patient's status indicates that such treatment should be continued for a longer period of time. Any patient continued on methadone for longer than 2 years must be subject to periodic reconsideration for discontinuance of such treatment.

A program is permitted, at the time of application or any time thereafter, to request exemption from or revision of specific program standards. The rationale for an exemption or

revision must be thoroughly documented in an appendix to be submitted with the application or at some later time. An example of a case in which an exemption might be granted would be for a private practitioner who wishes to treat a limited number of patients and requests exemption from some of the staffing and service standards in a non-metropolitan area with few physicians and no rehabilitative services geographically accessible. The FDA will approve such exemptions or revisions of program standards at the time of application with the concurrence of DACC.

The FDA has the right to withhold the granting of an exemption until such time as a program is in actual operation in order to assess if the exemption is necessary. If periodic inspections of the program reveal that discrepancies or adverse conditions exist, the FDA must reserve the right to revoke any or all exemptions previously granted.

The program sponsor must report any patient death which is considered methadone related to the FDA.

The program sponsor must report to the FDA the birth of any child to a female patient, if the newborn is premature or shows any adverse reactions which, in the opinion of the attending physician, are due to methadone, within 1 month of the birth.

There is a danger of drug dependent persons attempting to enroll in more than one methadone treatment program to obtain quantities of methadone for the purpose of self-administration or illicit marketing. Therefore, except in an emergency situation, methadone must not be provided to a patient who is

known to be currently receiving the drug from another treatment program using methadone.

The patient must always report to the same treatment facility unless prior approval is obtained from the program sponsor for treatment at another program. Permission to report for treatment at the facility of another program must be granted only in exceptional circumstances and must be noted on the patient's clinical record.

To prevent multiple enrollments, the program must agree to participate in any patient identification system that exists or is designated and approved by the FDA. Information that would identify a patient must be kept confidential.

Patient records must remain confidential. Any record that would divulge the name, diagnosis or prognosis of a particular patient cannot be used outside of the program unless a patient waives the privilege. The FDA and DACC may use these records only in actions involving the program or its personnel.

Before the FDA may deny or revoke an application, the applicant has the opportunity to question the information on which the proposal to deny or revoke approval is based, and to present any oral or written information and views. If, after this informal conference, the FDA finds no justification for the approval of the license, the applicant is entitled to a full hearing on the matter. The FDA may, however, subsequently reverse an adverse determination if it finds that the applicant has justified approval of the application.

The FDA has the power to hear appeals from treatment programs whose applications have been denied or revoked by DACC. This appeal is handled in much the same manner as a proposed FDA denial or revocation.

If the program sponsor or the person responsible for a particular program fails to abide by all the requirements set forth in these regulations, or fails to adequately monitor the activities of those employed in the program, he may have the approval of his application revoked, his methadone supply seized, an injunction granted precluding operation of his program, and criminal prosecution instituted against him.

APPENDIX C

LIST OF WITNESSES AT COMMISSION HEARINGS

ADAMS, HON. HAROLD, CSW,
Commissioner, Nassau County
Department of Drug & Alcohol
Addiction
September 5, 1974--Mineola

AMICO, HON. MICHAEL
Sheriff, Erie County
September 24, 1974--Buffalo

ANDERSON, MELVIN
Psychiatric Social Work
Coordinator, Nassau County
Probation Department
September 5, 1974--Mineola

ARASZEWSKI, JOSEPH, JR.
School Social Worker,
Mohonasen Central School
District No. 3, Schenectady
October 2, 1974--Poughkeepsie

BAILEY, WILLIAM
Chairman, Erie County
Narcotic Guidance Council
September 24, 1974--Buffalo

BIRNBAUM, JACK
Deputy Commissioner, New York
City Department of Corrections
September 4, 1974--New York City

BOUDREAU, HON. DONALD D., MD
Commissioner, County of Onondaga
Department of Mental Health
September 25, 1974--Poughkeepsie

BRAZIL, TONY
International Meditation
Society
October 2, 1974--Poughkeepsie

CASTIGLIA, THOMAS
Psychiatric Social Work
Coordinator, Nassau County
Probation Department
September 5, 1974--Mineola

CAGLIOSTRO, ANTHONY
Chairman, Drug Abuse Control
Commission, New York State
September 4, 1974--New York City

COHEN, MELVIN, PhD
Research Department, Hillside
Hospital
September 5, 1974--Mineola

CONSROE, ROBERT, MSW
1012 Crisis Center, Inc.
September 25, 1974--Syracuse

COSSE', JAMES W.
Motivational Counselor
Edgemont High School, Scarsdale
October 2, 1974--Poughkeepsie

COURTENAY, DANIEL, Deputy Chief
Commanding Officer, Narcotics
Division, New York City Police
Department
September 4, 1974--New York City

CUSHMAN, PAUL, MD
Clinical Director, Methadone
Maintenance Program, St. Luke's
Hospital
September 4, 1974--New York City

DOLE, VINCENT P., MD
Rockefeller University
September 4, 1974--New York City

DOUGHERTY, RONALD J., MD
Director, Drug Detoxification,
Aftercare & Methadone Main-
tenance, St. Mary's Hospital
September 25, 1974--Syracuse

ELWIN, EDWARD
Deputy Commissioner for Programs,
State Department of Correctional
Services
September 4, 1974--New York City

GILBERT, WILLIAM J., MSW, CSW
Administrative Director, Alco-
holism Services - Crouse-Irving
Memorial Hospital
September 25, 1974--Syracuse

GOODMAN, JEROME, PhD
Coordinator, Alcohol Programs,
Dutchess County Mental Health
Department
October 2, 1974--Poughkeepsie

GREGORY, CHARLES J.
Probation Administrator, Family Court Division, Representing Hon. William Dempsey, Administrative Judge, Family Court
September 5, 1974--Mineola

GRUBERT, ARTHUR
Chief, Unified Intelligence Division, New York City Task Force, U.S. Drug Enforcement Administration (Justice Department)
September 4, 1974--New York City

HATCH, CARL
Rochester Mental Health Center
September 24, 1974--Buffalo

HAYES, GERALD, ESQ.
Assistant District Attorney, Dutchess County
October 2, 1974--Poughkeepsie

HEILMAN, HON. JOHN R., JR.
Administrative Judge
Family Court
October 2, 1974--Poughkeepsie

HOLCOMB, HON. JOHN
District Attorney, Onondaga County
September 25, 1974--Syracuse

HORNBLASS, HON. JEROME
Commissioner, Addiction Services Agency, New York City
September 4, 1974--New York City

HOWE, ALFRED S., MD
Suffolk County Drug Treatment Services
September 5, 1974--Mineola

JONES, JAMES
Director, Topic House, Nassau County Department of Drug & Alcohol Addiction
September 5, 1974--Mineola

KEMP, JOHN
Director, Central Intake Unit, Drug Abuse Control Commission
September 25, 1974--Syracuse

KIPP, MICHAEL F.
Deputy Commissioner, Onondaga County Department of Mental Health
September 25, 1974--Syracuse

LEVY, HON. NORMAN J.
Senator, 8th District
New York State
September 5, 1974--Mineola

LIPTON, MARC P., PhD., MPA
Director, Addiction Services, Erie County Department of Mental Health
September 24, 1974--Buffalo

MADISON, GEORGE
Probation Supervisor II
Nassau County Probation Department
September 5, 1974--Mineola

MARK, RAPHAEL
Chairman, Dutchess County Narcotic Guidance Council
October 2, 1974--Poughkeepsie

MASLINE, GARY, J.D., MSW
Assistant Director, Children's Hospital Drug Abuse Program (DHARMA)
September 24, 1974--Buffalo

MATTINA, HON. JOSEPH S.
Erie County Court
September 24, 1974--Buffalo

MELCHIONDA, RONALD
Program Director, Methadone Maintenance Clinic, Nassau County Department of Drug & Alcohol Addiction
September 5, 1974--Mineola

MIRINGOFF, MARC, PhD
Coordinator, Alcohol Programs,
Dutchess County Mental Health
Department
October 2, 1974--Poughkeepsie

MORDINO, JOSEPH, ESQ.
Office of the
Erie County District Attorney
September 24, 1974--Buffalo

NEIMER, HON. RAYMOND
Judge of the Family Court, Buffalo
September 24, 1974--Buffalo

NESTER, MARTIN F., JR.
Administrator, Long Beach
Memorial Hospital
September 5, 1974--Mineola

NEWMAN, ROBERT G., MD
Assistant Commissioner,
Addiction Programs, New York City
Health Services Administration
September 4, 1974--New York City

PACHTER, IRWIN J., PhD
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Bristol Laboratories
September 25, 1974--Syracuse

PERKINS, MARVIN E., MD
Director, Community Mental
Health Board - Westchester
County
October 2, 1974--Poughkeepsie

RANDALL, ARTHUR, ESQ.
Chief Narcotics Bureau - Office
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September 5, 1974--Mineola

RATNER, RICHARD
Director of Vocational Services,
Nassau County Department of
Drug & Alcohol Addiction
September 5, 1974--Mineola

REILLY, DENNIS
Director of Family Counseling
SNG Counseling Center
September 5, 1974--Mineola

ROSENTHAL, MITCHELL S., MD
Director, Phoenix House
September 4, 1974--New York City

RUNES, RICHARD, ESQ.
Legal Aid Society
September 4, 1974--New York City

RUOCCO, PATRICIA
Vocational Counselor,
Nassau County Department of
Drug & Alcohol Addiction
September 5, 1974--Mineola

SCRIVENER, HARRY M., CSW
Program Director, SNG
Counseling Center
September 5, 1974--Mineola

SMITH, CEDRIC M., MD
Director, Research Institute
on Alcoholism
September 24, 1974--Buffalo

TOMSON, HON. BERNARD
Judge of the County Court,
Nassau County
September 5, 1974--Mineola

VIVAS, ELIZABETH, ACSW
Coordinator, Children's
Committee, Dutchess County
Family Counseling Service
October 2, 1974--Poughkeepsie

VOLPE, FRED
Director, Delphi Day Center,
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September 24, 1974--Buffalo

WILLIAMS, HON. JOSEPH B.
Deputy Administrative Judge
of the City of New York,
Family Division
September 4, 1974--New York City

YOUNG, DAVID
Director, Threshold - Rochester
September 24, 1974--Buffalo

ZAKS, ARTHUR, MD
Director, Eastside Center
September 4, 1974--New York City

WITNESSES AT A JOINT HEARING ON DRUNK DRIVING
HELD BY
THE TEMPORARY STATE COMMISSION TO
EVALUATE THE DRUG LAWS
THE JOINT SELECT COMMITTEE ON TRANSPORTATION,
AND THE
SENATE STANDING COMMITTEE ON TRANSPORTATION
MINEOLA, N.Y., OCTOBER 17, 1974

ADAMS, HAROLD A.
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Inspector, Nassau County
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N.Y. State Magistrates
Association

MORRELL, WILLIAM
Inspector, Commanding Officer or
Highway Patrol, Bureau of Police,
Suffolk County

PEACE, ERNEST
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Development of the N.Y. Traffic
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ROBBINS, HON. ALFRED S.
Administrative Judge of the
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Lieutenant, New York State
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